HEALTH INSURANCE OPTIONS: HEALTH INSURANCE STATUS OF THE INDIGENT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

JUNE 27, 1991

Serial 102-46

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

46-756⇆ WASHINGTON : 1992

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-037366-2

COMMITTEE ON WAYS AND MEANS

DAN ROSTENKOWSKI, Illinois, *Chairman*

SAM M. GIBBONS, Florida
J.J. PICKLE, Texas
CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ANDY JACOBS, JR., Indiana
HAROLD E. FORD, Tennessee
ED JENKINS, Georgia
THOMAS J. DOWNEY, New York
FRANK J. GUARINI, New Jersey
MARTY RUSSO, Illinois
DON J. PEASE, Ohio
ROBERT T. MATSUI, California
BERYL ANTHONY, JR., Arkansas
BYRON L. DORGAN, North Dakota
BARBARA B. KENNELLY, Connecticut
BRIAN J. DONNELLY, Massachusetts
WILLIAM J. COYNE, Pennsylvania
MICHAEL A. ANDREWS, Texas
SANDER M. LEVIN, Michigan
JIM MOODY, Wisconsin
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington

BILL ARCHER, Texas
GUY VANDER JAGT, Michigan
PHILIP M. CRANE, Illinois
DICK SCHULZE, Pennsylvania
BILL GRADISON, Ohio
BILL THOMAS, California
RAYMOND J. McGRATH, New York
ROD CHANDLER, Washington
E. CLAY SHAW, JR., Florida
DON SUNDQUIST, Tennessee
NANCY L. JOHNSON, Connecticut
JIM BUNNING, Kentucky
FRED GRANDY, Iowa

ROBERT J. LEONARD, *Chief Counsel and Staff Director*
PHILLIP D. MOSELEY, *Minority Chief of Staff*

SUBCOMMITTEE ON HEALTH

FORTNEY PETE STARK, California, *Chairman*

MARTY RUSSO, Illinois
BRIAN J. DONNELLY, Massachusetts
WILLIAM J. COYNE, Pennsylvania
SANDER M. LEVIN, Michigan
JIM MOODY, Wisconsin
BENJAMIN L. CARDIN, Maryland

BILL GRADISON, Ohio
ROD CHANDLER, Washington
NANCY L. JOHNSON, Connecticut
RAYMOND J. McGRATH, New York

CONTENTS

HEALTH INSURANCE OPTIONS: HEALTH INSURANCE STATUS OF THE INDIGENT

THURSDAY, JUNE 27, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:45 a.m., in room B-318, Rayburn House Office Building, Hon. Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
THURSDAY, JUNE 13, 1991

PRESS RELEASE #15
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON HEALTH INSURANCE OPTIONS:
HEALTH INSURANCE STATUS OF THE INDIGENT

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on health insurance options: health insurance status of the indigent. The hearing will be held on Thursday, June 27, 1991, beginning at 10:30 a.m., in room B-318 Rayburn House Office Building.

In announcing the hearing Chairman Stark said, "The one health financing issue on which there is substantial agreement is that we need a single Federal program to assure health care for the indigent. Providing every American with decent health insurance through a patchwork quilt at the State or local level is virtually impossible."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

Of the 34 million Americans without health insurance, approximately one-third have incomes below the Federal poverty level and another one-third have incomes between 100 and 200 percent of the poverty level. Medicaid, the Federal-State program of health coverage for the poor, covers only 42 percent of U.S. residents below the poverty level.

Substantial numbers of indigent persons are without health coverage, and many rely increasingly upon hospital emergency rooms and outpatient departments as a source of health care. The American Hospital Association reports that uncompensated care provided by hospitals has increased from less than $6 billion in 1980, to over $10 billion in 1988.

For families without adequate health insurance coverage, any encounter with the health care delivery system presents serious financial consequences. These families appear to avoid seeking appropriate health care when needed. A 1986 survey by the Robert Wood Johnson Foundation, in which 13.5 million Americans reported not receiving medical care for financial reasons, confirmed a decline in access to care since the Foundation's 1982 study. The studies indicated that between 1982 and 1986 there was an eight percent decline in physician visits by the poor who were in fair or poor health.

(MORE)

Lack of health insurance coverage often means that proper care is delayed until the problem is serious. Research shows that uninsured persons are less likely to see a physician in a year, less likely to have children appropriately immunized, less likely to receive prenatal care, and less likely to see a physician if they have serious symptoms.

According to a report by the American Academy of Pediatrics, only 11 percent of children without health insurance reported excellent health, while 78 percent of children with private insurance coverage reported excellent health. The report also found that children who did not visit a doctor in the last year were twice as likely to be without health insurance as children who made more than four visits.

In addition, according to report, the proportion of children aged one to four who were immunized against each of the major childhood diseases declined between 1980 and 1985; the proportion of children immunized against measles dropped from 64 to 61 percent; and the proportion of children immunized against polio dropped from 78 percent in 1970, to only 55 percent in 1985. Fully one-quarter of all preschoolers, and one-third of all poor children, are not immunized against the common childhood diseases.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Thursday, July 11, 1991, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman STARK. Good morning. The Health Subcommittee of Ways and Means will continue its series of hearings on health insurance options with a discussion today of the health insurance status of the indigent.

There are 34 million Americans without health insurance. As you know, that often means that proper care is delayed, or it may never be available.

The lack of insurance is particularly acute for the poor. These families have to deal with any encounter with the health care delivery system, and no matter how minor that encounter is, or how routine, there are often serious financial consequences, if not barriers. One-third of the uninsured have incomes below the poverty level, and by that we mean under $6,000. Another third have incomes between that level and $12,000 a year.

Some have suggested that one way to respond to the problem is to expand the current Medicaid program or to replace it with a similar Federal-State program under another name.

Unfortunately, the current problems of Medicaid have convinced the Chair that it cannot be considered as a model for a national program.

Given the fiscal pressures on States, particularly at low points in the business cycle, a Federal-State program will always have difficulty providing adequate financing to the health care system.

In my view, the one health financing issue on which there should be substantial agreement is that we need a single Federal program to assure health care for the indigent. Providing every American with decent health insurance through a patchwork quilt at the State or local level is virtually impossible.

I hope our discussion today will provide further insight into these issues. I think that for those who concern themselves that Medicare might go the route of Medicaid, I can assuage their fears.

I apologize for my tardiness. I just came from a convention of people interested in long-term care and long-term health insurance. There were maybe 250 people there; 60 or 70 percent were insurance companies and providers, and a sprinkling of public interest groups or advocates for the poor. It seemed apparent that in this group, just the AARP and the American Council of Life Insurance, probably made more political contributions, just those two groups, in 1 year than advocates for the poor and the homeless and children have made in the last 50 years.

The reason that I think Medicare is safe is that there is a strong, active, political structure that will protect the interests of the seniors. If you have them speaking for a single Federal program, I don't think you have to worry that Congress won't fund it, quite frankly. And for those of us who were active in making a few minor changes to the catastrophic bill know, when the seniors get involved in something, Congress generally reacts.

[Chairman Stark's opening statement follows:]

OPENING STATEMENT
THE HONORABLE PETE STARK
CHAIRMAN, SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS

HEARING ON HEALTH INSURANCE OPTIONS:
HEALTH INSURANCE STATUS OF THE INDIGENT

Today the Subcommittee continues its series of hearings on health insurance options with a discussion of the health insurance status of the indigent.

Thirty-four million Americans are without health insurance. Lack of health insurance coverage often means that proper care is delayed until the problem is serious. Research shows that uninsured persons are less likely to have children appropriately immunized, less likely to receive prenatal care, and less likely to see a physician if they have serious symptoms.

The problem of the lack of insurance is particularly acute for the indigent. For these families, any encounter with the health care delivery system, no matter how minor or seemingly routine, presents serious financial consequences. One-third of the uninsured have incomes below the poverty level and another third have incomes between that level and twice the poverty level.

Some have suggested that one way to respond to the problem of lack of insurance is to expand the current Medicaid program or to replace it with a similar federal-state program under another name.

Unfortunately, the current problems of Medicaid have convinced me that it cannot be considered a model for a national program.

Given the fiscal pressures on states, particularly at low points in the business cycle, a federal-state program is always going to have difficulty providing adequate financing to the health care system.

In my view, the one health financing issue on which there should be substantial agreement is that we need a single federal program to assure health care for the indigent. Providing every American with decent health insurance through a patchwork quilt at the state or local level is virtually impossible.

Medicaid also limits access through inappropriately low payments to hospitals and doctors, particularly doctors. I have introduced two bills to respond directly to this problem, H.R. 2656 and 2657, which would require states to raise Medicaid reimbursement to the Medicare levels. However, passage of these bills is not a panacea, because the basic problems of Medicaid would remain.

There is also the further problem of sustaining public support for a large public program. It is an unfortunate fact of life in our society that a program for the poor too often becomes a poor program. A comprehensive program which provides benefits, and shares risks, to every American would be the most cost-effective and sustainable health program we could enact.

I hope our discussion today will provide further insight into the issues which must be resolved in providing universal coverage for all of our citizens. I look forward to the expert testimony of our witnesses in that light.

Chairman STARK. Mr. Coyne.

Mr. COYNE. I have no statement.

Chairman STARK. I am assured that the absence of our Republican colleagues is not from lack of interest in this issue, but as you all know, the House adjourned somewhat earlier than we intended, and my ranking member, Mr. Gradison, has an important budget meeting this morning and sends his apologies.

Our first panel consists of Stuart Eizenstat, an old friend of the committee, who is counsel to the National Association of Public Hospitals; Dr. Karen Davis, another old and welcome friend, who is from the Department of Health Policy and Management of Johns Hopkins University; and Dr. Deborah Freund, who is from the School of Public and Environmental Affairs, Indiana University, in Bloomington, Ind.

If the three panelists will join us. Please summarize or expand on your written statement submitted to the committee, what you say will without objection be made part of the record. If any of you have subsequent answers or questions that may come up during the hearing, the record will be kept open for a sufficient length of time for us to receive further comments and questions and responses.

Having said that, Stu, do you want to start off?

STATEMENT OF STUART E. EIZENSTAT, COUNSEL, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Mr. EIZENSTAT. Thank you, Mr. Chairman. It is a pleasure to be here.

I am Stu Eizenstat, counsel to the National Association of Public Hospitals. I was President Carter's chief domestic policy adviser and serve now as a lawyer, and as a lecturer at the John F. Kennedy School of Government at Harvard.

NAPH represents the institutions which comprise America's most important health and hospital system: the major tertiary care teaching hospitals which truly serve as national health insurance by default in our Nation's metropolitan areas.

I am pleased to have this opportunity to comment on the health insurance status of the indigent and the urgent need for reform, and I applaud your leadership in this area, Mr. Chairman.

If I can impress upon you only one thing this morning, it is this: Health care coverage in America is a social and moral disgrace, and it is costing all Americans needless billions of dollars each year.

The American system of health care is morally bankrupt, and its costs are increasingly placing punishing burdens on corporations, families, and individuals. Reform is imperative and must consist of some form of national health coverage with tough cost controls.

Permit me to illustrate the dimensions of the problem. As you mentioned, Mr. Chairman, 34 million Americans are without health insurance, but another 60 million have health insurance that is inadequate in the event of a serious illness. The Census Bureau has indicated recently that some 65 to 70 million Americans will, during some period of a 2-year span, have no health insurance whatsoever.

The core of our national disgrace is the failure of the Medicaid program to fulfill its mission. It now covers less than half of the Americans who are living below the Federal poverty level, compared to 65 percent some years ago. Even though the total number of recipients has remained remarkably constant since 1974, Medicaid costs have risen astronomically—$12.5 billion in fiscal year 1975, to $48 billion in fiscal year 1988, to $89 billion in fiscal year 1991, and $105 billion expected this coming year. On the average, Medicaid pays doctors only 69 percent of what Medicare would for comparable treatment.

Eligibility levels in many States are a disgrace. For example, a family of three living in Alabama would have to earn less than $1,416 annually to be poor enough to qualify for Medicaid.

Medicaid is failing special populations. In 1988, for example, 61 percent of AIDS patients at our member hospitals in the South were self-pay or uninsured. That same year, nearly a third of all discharges of all inpatient days were totally unsponsored, even by Medicaid, in NAPH member hospitals, and 42 percent of all outpatient visits were uninsured.

For some safety net hospitals, these proportions are even higher. Near you, Mr. Chairman, San Francisco General Hospital, 62 percent of all inpatient days and 72 percent of all outpatient visits were unsponsored. And you are well aware of the problems based on your own knowledge——

Chairman STARK. When you say unsponsored, does that mean unpaid?

Mr. EIZENSTAT. It means the patient does not have Medicare, Medicaid, or private insurance.

Chairman STARK. That is a euphemism for something uncompensated.

Mr. EIZENSTAT. The patients have neither public or private coverage.

Chairman STARK. And they don't collect.

Mr. EIZENSTAT. Roughly. Counties receive some matching funds from the State, and may pass some of these moneys to providers for certain narrow categories of patients, but the patients themselves remain unsponsored.

You are well aware of these problems based on your knowledge of Highland Hospital in your own district. Obstetric units are overflowing. In effect, we have become the primary care physicians for low-income people. That is not what was intended.

Emergency and clinic patients are waiting longer and longer to see doctors or to be admitted. Fifty-eight percent of NAPH hospitals reported periodic waits by emergency department patients of 12 hours or more for admission. Half of all hospitals surveyed reported that some patients were forced to wait more than 24 hours to get simple service.

In short, while we are all debating how to provide access to care, the Nation's safety net hospitals are providing that care now, and they are providing it to more and sicker people than at any other time in our Nation's history. It is imperative that Federal policymakers respond to these needs with comprehensive reforms.

The consensus for change in this country is at a 40-year high. In nine surveys since 1989, between 60 and 72 percent of the American people favored a universal program.

Normally, Mr. Chairman, I would describe myself as a "roaring incrementalist." I believe that incremental change is best suited to our system of government, with its divided and dispersed power and with its checks and balances. But health care reform is an exception to the rule. We have simply come to a point where the existing superstructure is too weak for incremental reform to work.

There may be finally a convergence of enough interests opposed to the current system to create a consensus for major structural changes, and let me quickly explain why.

Corporations are finding health care costs are their fastest-rising expenditure and eating into profits. Middle-class families are faced with staggering health care costs and constant hassles about coverage. Millions of working Americans have no coverage at all. States are overwhelmed by Medicaid mandates——

Chairman STARK. I apologize for the new bell and whistle that we have.

Mr. EIZENSTAT. That is why I totally ignored it. [Laughter.]

Chairman STARK. Continue.

Mr. EIZENSTAT. States are faced with soaring Medicaid costs, last year 18 percent increases, this year perhaps 25 percent. The AMA itself is beginning to recognize the need for reform. Physicians are dropping out of the current system because of low reimbursement levels, and public hospitals are, as I indicated, becoming primary care physicians.

When you put all of these interests together, you begin to have a consensus for the kind of change that you and your committee are examining. To be truly effective, a nationwide program is an essential component. While there has been activity in a handful of States, it is clear these efforts will never lead to what needs to be done.

I am delighted to see that several important proposals have been developed recently, including your Mediplan; a universal coverage proposal introduced by Senators Mitchell, Rockefeller, and Riegle; an interesting new proposal from former Social Security Commissioner Robert Ball, and one from the Pepper Commission.

Basic components of this structural change are as follows: universal access or coverage for all, breaking the Medicaid/AFDC link as it has been broken for children. A national health plan must require the federalization of at least significant parts of the Medicaid program and quite possibly its elimination and merger with Medicare.

I would personally be willing to transfer significant Federal infrastructure and social service categorical programs to the States to remove, in turn, part or all of the Medicaid burden from their shoulders.

A core national minimum benefit package must be developed that is not too rich to be affordable, yet covers essential preventive, primary care, hospital care, and guards against the prospects of catastrophic illness.

The present system of private insurance can continue under a national plan, but insurance reform is an essential part of any na-

tional health package. The Federal Government should set national standards for health insurance plans which include mandating a minimum benefit package on all employers above a reasonable size, reinstating community rating and curbing exclusion of preexisting conditions, and post-illness coverage limits on specific diseases.

There will always be individuals who will fall through the cracks even with this kind of system, and such persons should be provided with strong and well-financed institutional safety nets, like our public hospitals. There must be a disproportionate share adjustment for outpatient services, or the hospitals like ours which are bearing the weight of the disintegrating Medicaid physician network will suffer a further decline of their already weak financial condition.

Any national plan must also include a heavy emphasis on preventive and primary care, and there must be strict cost controls as part of any plan.

If we agree on these principles, Mr. Chairman, Mr. Coyne, and members of the committee, we should welcome diverse proposals for implementing them. There are many ways to finance these principles. I would even welcome conservative market-based approaches as well as more traditional ones. I have no doubt that if we can simply agree on these principles, that we can work together as a Nation to develop a financing system which is adequate and equitable.

Mr. Chairman, on behalf of the governmental and private entities that comprise the NAPH, I applaud your efforts and those of your committee. I am pleased to offer our help to you, Mr. Chairman, in reaching the goals that you have set forth in your legislation.

[The prepared statement follows:]

Statement of Stuart Eizenstat
Counsel

National Association of Public Hospitals

before the

Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives

June 27, 1991

Mr. Chairman, members of the Subcommittee, I am Stuart Eizenstat, Counsel to of the National Association of Public Hospitals (NAPH). I served as Assistant to the President for Domestic Affairs and Policy in the Carter Administration, and am an adjunct lecturer at the John F. Kennedy School of Government, at Harvard. NAPH represents 100 of America's metropolitan area safety net hospitals. This may seem like a small number, but these 100 institutions comprise America's most important health and hospital system. With combined revenues of over $10 billion, these major, tertiary care teaching hospitals truly serve as "national health insurance" by default in our nation's urban areas.

I am pleased to have this opportunity to comment on the health insurance status of the indigent and the urgent need for reform. Comprehensive health care reform continues to be a significant topic of public debate. Mr. Chairman, your recently introduced Mediplan Health Care Act is an important and welcome step forward in seriously addressing this problem. Senators Mitchell, Kennedy, Riegle, and Rockefeller have also introduced a proposal to provide coverage for all Americans. Robert Ball, former Commissioner of the Social Security Administration, has recently proposed an interesting, multi-facetted approach to universal coverage. The Pepper Commission report and recent GAO examination of the Canadian system have also helped keep the need for comprehensive reform in the policy spotlight.

This level of attention is necessary. Let me illustrate the urgency of this situation:

- 34 million Americans are completely without health insurance; another 60 million have health insurance that will prove inadequate in the event of a serious illness.

- The Medicaid Program now covers less than half of the Americans who are living below the federal poverty level. Eligibility levels in many states are a disgrace; for example, a family of three living in Alabama would have to earn less than $1416 per year to be poor enough to qualify for Medicaid.

- Physician participation in the Medicaid Program is decreasing rapidly, leaving beneficiaries to seek care in already overcrowded public hospitals or, worse, to forgo needed care entirely.

- Safety net hospitals are bursting at the seams. 55 NAPH member hospitals across the nation averaged an 81% occupancy rate in 1988, with many hospitals approaching 100%.

- In 1988, nearly 34% of all discharges and 29% of all inpatient days were unsponsored -- even by Medicaid -- in NAPH member hospitals; 42% of all outpatient visits were uninsured. For some safety net hospitals, these proportions are far higher. At San Francisco General

Hospital, 62% of all inpatient days and 72% of all outpatient visits were unsponsored; for Dallas' Parkland Memorial Hospital, the figures were 54% of inpatient days and 62% of OPD visits. Obstetric units are overflowing.

- Emergency and clinic patients are waiting longer to see doctors or be admitted. 58% of NAPH hospitals reported periodic waits by emergency department patients of 12 hours or more for admission, and half of all hospitals surveyed reported that some patients were forced to wait more than 24 hours.

In short, while you are debating how to provide access to care, the nation's Safety Net hospitals are providing that care **now**, and they are providing it to more and sicker people than at any other time in our nation's history. It is imperative that policy-makers respond to these needs; NAPH member hospitals strongly believe that both incremental and comprehensive reforms and initiatives must be considered and enacted.

Our failure to provide universal health coverage and access to care is one of the most important social, economic, and ethical problems facing all Americans. In only the past 20 years, there have been nearly a dozen major national health insurance initiatives, offered by some of the most important political leaders of our era. Unfortunately, each of these proposals generated influential opposition, virtually paralyzing efforts to achieve needed reform. Indeed, national health coverage is an issue that has generated heated debate ever since Ohio's Senator Bob Taft coined the term "socialized medicine" to denigrate Harry Truman's modest proposals over 40 years ago. By the mid 1980s, the onset of Reaganomics and our preoccupation with the budget deficit had eclipsed attention to anything other than incremental efforts at improvement. As a result, despite the fact that there is a growing consensus that universal coverage is the very foundation of a humane and civilized society, we have advanced little in this arena since the enactment of Medicare and Medicaid.

We are pleased that this Committee is interested in a serious review of health insurance alternatives. At the outset, however, I would like to remind this Committee that one of the main reasons we have had the luxury of debating rather than enacting universal health coverage all these years is because of a small and fragile safety net comprised of two to three hundred public and nonprofit hospitals, mostly in urban areas. Our hospitals are becoming a substitute for unaffordable physicians for an increasing number of Americans. The condition of many of these essential safely net hospitals has deteriorated substantially in recent years, and is far worse today then when universal health coverage was last seriously debated.

In the remainder of my testimony this morning, I would like to accomplish three things: first, provide you with recommendations for reform, and summarize our concerns about current indigent care funding; second, describe the immediate incremental reforms which are urgently required to keep the safety net intact until a universal insurance program becomes a reality; and third, provide you with some additional data on the condition of NAPH member hospital today, as they struggle to serve the growing number of uninsured and underinsured.

I. SUMMARY OF COMMENTS & RECOMMENDED REFORMS

The Federal Government Must Act To Guarantee Access To Health Care For All Americans.

Universal health coverage must remain the most important legislative and policy goal of our nation's health system. To be truly effective, NAPH members believe that a nationwide program is an essential component of genuine health coverage reform. While there has been a high level of activity and discussion in a small handful of states, such as the trailblazing actions of Hawaii and Massachusetts, we believe these efforts will not lead to

true universal access. For example, Hawaii's universal coverage program benefits greatly from that state' geographic and economic isolation, as well as from a hard-to-replicate ERISA exemption that permits the state to regulate self-insured employers. While ambitious in concept, the Massachusetts experiment now appears very close to being dismantled -- a casualty of that state's economic plight.

Several states have recently enacted risk pools or other limited demonstration programs which apply initially only to certain parts of the state, or to subgroups within the general population. Other states, like California, New York, Michigan, Illinois and Oregon, have proposals in the hopper, but with no clear promise of enactment. All in all, while there is considerable discussion of states becoming the laboratory for a universal health coverage plan, their performance to date has been disappointing.

Given this track record, NAPH members remain convinced that the federal government must take the lead in achieving this goal, instead of abdicating leadership to the states. NAPH is pleased to set forth some essential criteria for any program of universal health access and coverage for all Americans. The following principals, **at a minimum,** have been endorsed by NAPH member hospitals as essential to any national health plan:

- While incremental improvements are acceptable in their own right, the goal of any national health plan must be **nothing less than universal access or coverage for all.**

- A national health plan must require the federalization of at least significant parts of the Medicaid program, and quite possibly its elimination and merger with Medicare.

- A core national minimum benefit package must be developed that is not too rich as to be unaffordable, yet covers essential preventive, primary care and hospital services, and guards against the prospects of catastrophic illness.

- The present system of private insurance can continue under a national health plan, but insurance reform is an essential part of any national health package; the federal government should set national standards for health insurance plans, which include mandating minimum benefit packages on all employers above a reasonable size, reinstatement of community rating, and curbing current trends toward exclusion of preexisting conditions (or setting post-illness limits on specific diseases such as AIDS).

- Not every individual needs to receive **insurance** coverage to be guaranteed access under a universal health plan; it must be recognized that there will always be individuals who fall through the cracks, and that it is acceptable to provide access for such persons through the preservation of a strong and well-financed **institutional safety net.**

- States must be permitted wider latitude to experiment with new plans, including the ability to waive ERISA constraints on the regulation of self-insured businesses.

- Any national plan must include a heavy emphasis on preventive and primary care and must provide adequate support for initiatives to encourage changes in lifestyles.

If we can agree on these principles, we can then welcome proposals for implementing them. I welcome conservative, market-based approaches, as well as more traditional proposals. The key is to agree on the need to move forward. The universal access proposals I mentioned earlier would rely on a variety of "pay or play" plans; many would utilize some

form of new federal-state partnership to replace Medicaid. These plans are coupled with a variety of proposed financing methods, and frankly, Mr. Chairman, many of these financing proposal could work. I have no doubt that we can work together to develop a financing system which is adequate and equitable. But we must first agree that the present situation is no longer tolerable.

A common misconception with respect to our nation's health system is that we lack the resources to both expand access for the uninsured, on the one hand, and preserve the quality of care most Americans have come to expect, on the other. Nothing could be further from the truth. Overall health spending exceeded $600 billion in 1990 -- up from $230 billion in 1980 -- and annual per capita spending approached $2,600 -- or over $10,000 for a family of four! Even the most conservative observers estimate that those figures will double by the year 2000. The American Academy of Pediatrics estimates that providing a basic benefit package for the nation's 10 to 12 million uninsured children would cost just $458 per year per child.

We now have a unique opportunity to act, as nearly every element of society is increasingly feeling the strain of our inadequate health insurance system. There is a growing consensus that the current health care system cannot remain unchanged:

- States are overburdened by new Medicaid mandates;
- Corporations find health care costs to be their fastest-rising expense item;
- Physicians and hospitals are burdened with a $100 billion annual paperwork cost;
- The middle class is battered by soaring costs;
- The health care system leaves large numbers of people uncovered.

A growing number of the middle class find themselves uninsured for months at a time. A census bureau study has shown that more than one out of every four Americans will find themselves without health insurance for a substantial period at some time during the next three years. Those who are insured watch as their share of the costs of coverage increase rapidly. The Labor Department reported that while health insurance payments and Social Security taxes (adjusted for inflation) rose by 1.9% last year for most of the workforce, wages fell by 2 percent.

In many areas, over-burdened public hospitals will require more middle class tax dollars to stay afloat. Consensus for change is at a 40-year high: in nine surveys conducted on this issue since 1989, 60 to 72 percent of those surveyed support a universal insurance program.

Business coalitions are now seriously considering national coverage proposals. The costs of providing has insurance have exceeded what anyone would have imagined only a few years ago. For many major companies, the costs of covering their retirees has surpassed the costs of covering their active workers: Chrysler supports one retiree for every active worker; Bethlehem Steel is responsible for two retirees for each active worker. For these and other established companies whose health plans cover more older workers and retirees, health care costs are eroding their ability to compete in international markets.

The American Medical Association has begun to recognize the imperative for change.

Governments at all levels have been hit hard. Between 1966 and 1991, the federal cost of the Medicaid Program rose from $789 million to $46.4 billion. As described below, state budgets have been severely strained by rising federal mandates and deteriorating economic conditions.

Of course, the most deeply harmed are the millions of Americans to whom we have not provided adequate health care coverage. Without question, the core of this disgrace is the failure of the Medicaid program to fulfill its mission.

The Medicaid Program Is Failing To Serve Its Constituency While Draining State Budgets.

At this point the evidence is clear and we must be honest with ourselves: the Medicaid Program has failed to make health care available to our nation's poor. Nationally, the Medicaid Program covers only 48.4% of persons living below the federal poverty level -- compared to over 65% some years ago.

The Medicaid/AFDC link is a significant component of this problem, as AFDC support levels are eroded by inflation. Congress has recently taken important steps to break the Medicaid/AFDC link for children. We must provide the same protection to poor citizens of all ages -- the wide disparity in Medicaid eligibility levels is a disgrace. For example, a family of three living in Alabama would have to earn less than $1416 per year (13.4% of the federal poverty level) to be poor enough to qualify for Medicaid in that state; in California, that same family would qualify with an annual income of $8328 (still only 79% of the federal poverty threshold). The AFDC-linked Medicaid threshold annual income for a family of three is $2208 (21% of the federal poverty level) in Texas, $7476 in New York (71%), $5052 (48%) in Colorado, $3996 (38%) in Delaware, and $4404 (42%) in Illinois.

Further exacerbating the problem is the fact that inadequate Medicaid reimbursement levels in many states are forcing physicians to drop out of the Program entirely; pediatricians have been particularly hard hit. On average, Medicaid Programs pay pediatricians less than 2/3 of the fees they would receive from private patients for the same services.

Of 48 states responding to a national survey, 44 noted problems with physician participation in Medicaid; low fees were cited at the most common reason for nonparticipation. According to the Physician Payment Review Commission, for commonly used Medicaid services, on average Medicaid pays physicians 69% of what Medicare would pay. According to the PPRC's index of comparative physician payment, the Medicaid Programs in sixteen states paid less than 65% of what Medicare would have paid for the same services; several states' Programs pay less than 40%. The Medicaid Programs in only 9 of the 48 responding states paid above 90% of what Medicare would have paid. We thus cannot be surprised to learn that, between 1987 and 1989, the proportion of pediatricians who refused Medicaid patients jumped from 15% to 23%, and those who limit the size of their Medicaid patient load increased from 26% to 39%.

When physicians are not available, beneficiaries are forced to seek care from already overburdened public hospitals. For 1988, 25% of outpatient visits to NAPH member hospitals were by Medicaid patients. Medicaid payment to hospitals for these outpatient services are typically well below cost; in the absence of a disproportionate share adjustment for outpatient services, the hospitals which are bearing the weight of the disintegrating Medicaid physician network will suffer further decline of their already weak financial condition. The hospital emergency room is the least cost-effective location for a physician office visit. But even worse, when physicians are unavailable, many people simply do not seek needed care at all.

To date, the Congressional response has been to increase the federal mandate, but without providing a financing structure to support that mandate. It is wishful thinking to expand eligibility and coverage mandates without regard for the ability of the states to pay. The inverse relationship between level of Medicaid payment to providers and extent of Medicaid coverage is no accident. States' Medicaid spending rose 18% last year, and projections indicate that another 25% increase may be expected this year. Spending is projected to increase from $31 billion last year to $67 billion by 1995; the National

Governors Association has petitioned Congress for a two year suspension of newly enacted Medicaid mandates.

Since Medicaid 1974, the number of recipients has remained remarkably constant (22 million in 1975 versus 26 million last year), while the costs of the Program have skyrocketed from $9.7 billion to a projected $105 billion for 1992. Leaving cost control to the states, while attractive in theory, simply does not provide the single locus of decision-making required for an effective and enforceable cost-control mandate.

Meanwhile, the numbers and needs of the uninsured continues to rise. Over 30% of inpatient days and 52% of outpatient visits to NAPH member hospitals were by uninsured patients in 1988. Over 50% of the emergency room and trauma care delivered in urban public hospitals nationally is for uninsured patients. For 57 member Hospitals, 35% of gross charges were attributable to uninsured patients in 1988; for this population, average patient care collections were just 24.6%. For 1988, 36% of inpatient days were Medicaid patients. Overall, gross charges for Medicaid patients in safety net hospitals averaged nearly $55 million per hospital in 1988, while collections averaged only $39.8 million (or 72%). The proportions of privately insured, Medicare, and Medicaid patients have decreased in the last several years, while the proportion of uninsured has increased.

The numbers and needs of special populations -- including persons with AIDS, drug abusers, trauma victims, the homeless -- are growing rapidly. For example, a survey of 15 NAPH member hospitals indicated that 29% of all emergency department visits were drug-related in 1988. Another survey of 30 NAPH member hospitals reported a 17% increase in the number of cocaine-addicted newborns between 1988 and the first half of 1989. These problems are not limited to New York and California -- they affect middle America as well. For example, 15% of all babies born at Kansas City's Truman Medical Center last year had traces of cocaine in their blood.

The number of AIDS inpatients treated in NAPH member hospitals has tripled since 1985; inpatient days during that period also increased threefold. There are today 2,000 AIDS patients in New York City hospital beds -- patients who that essentially did not exist just five years ago. This total is projected to double by 1993 or 1994. Fifteen percent of all inpatients at Dallas' Parkland Memorial Hospital are homeless --and nearly 50% of all inpatients who are HIV positive.

The financial costs of this epidemic cannot be overstated. NAPH member hospitals continue to lose money treating AIDS patients, losing an average of $4,903 for each admission. The financial situation is particularly troublesome in those parts of the country where Medicaid coverage is inadequate. This is graphically illustrated by examining the extent of Medicaid eligibility by region: 70% of AIDS patients were covered by Medicaid in the Northeast and 66% in the West, as compared with 44% in the Midwest and just 25% in the South. Conversely, only 10% of all AIDS patients in the Northeast were "self pay" patients, as compared with 23% in the West, 25% in the Midwest, and a whopping 61% in the South.

On most issues I favor incremental reform. Our political system has great difficulty making major, comprehensive change. However, the health care coverage and access situation in America today is simply intolerable, and the existing superstructure is simply too weak to support a continued incremental approach. Medicaid must be folded into the broader health care system. It lacks a powerful enough constituency to serve its function if left alone as a free-standing program. We must act nationally, and we must act now.

II. UNTIL UNIVERSAL COVERAGE BECOMES A REALITY, CONTINUED EFFORTS MUST BE MADE TO REFORM THE EXISTING PROGRAMS.

Medicaid Reforms Are Essential.

Until universal coverage becomes a reality, efforts to reform of the Medicaid Program must continue. Recent improvements in the Medicaid program have expanded eligibility for pregnant women and children; permitted states to continue using a variety of mechanisms for providing extra payments to disproportionate share hospitals; and allowed public and private hospitals to participate in the financing of Medicaid expansions through voluntary donations and the transfer of funds by local governments to states. In addition, states like Florida, New York and New Jersey have used provider taxes or all-payor systems to redistribute revenues and enhance Medicaid payments. **It is imperative that states be permitted to continue to make use of these alternative sources of revenues, at a time when many are suffering severe budget crises.**

However, even with the availability of the augmented payment sources described above, only about half of all states pay significant differentials to "disproportionate" safety net hospitals. And a number of states continue to subject hospitals to inadequate base payment rates as well, as is evidenced by the proliferation of lawsuits brought by hospitals against state Medicaid agencies around the country. **Both reasonable and adequate Medicaid payment rates, and meaningful disproportionate share hospital payments, must be enforced upon all states.** Mr. Chairman, your proposal to mandate minimum Medicaid payments to hospitals, tied to Medicare payment levels, is a welcome step in this direction.

The Indigent Care Role of the Private Sector Must Be Clarified and Strengthened.

Until universal coverage becomes a reality, the indigent care role of the private sector and other health care providers must be clarified and strengthened. The need for health services by uninsured patients continues to escalate dramatically; at the same time, competitive and reimbursement pressures are driving many private hospitals (and other providers) to aggressively seek ways to reduce services to uninsured safety net patients. Quite simply, the willingness and ability of private providers to shift the costs of uncompensated care to privately insured individuals have been significantly eroded in recent years. **But safety net patients should not have to rely on the grudging enforcement of legal rights against private hospitals.** We believe that mechanisms can and must be established to encourage a sharing of the burden by all health care providers, public and private, and that the business community must also be involved in this effort.

Medicare Disproportionate Share Hospital and Medical Education Adjustments Must Be Preserved and Increased.

Medicare is a relatively smaller proportion of the patient load in safety net hospitals than in the rest of the industry (only 18%, as compared to 34% on average for the industry as a whole). However, Medicare is the single most important third-party payor in many safety net hospitals, and as such, constitutes an essential part of patient care revenues.

Great strides have been made in mandating Medicare payment adjustment increases for "disproportionate share hospitals;" Congress has also refrained from making any further reductions in the indirect teaching adjustment. This has resulted for the first time in actual real dollar gains in Medicare reimbursement for safety net hospitals, although these gains have not succeeded in erasing the significant operating deficits of such hospitals (such deficits currently average over $9 million, or -6%).

Ironically, these real gains have also resulted in the Medicare disproportionate share adjustment coming under fire for the first time in the legislative process. In particular, it was argued in the 1990 reconciliation act debate that "it is not the role of the Medicare program to finance care for the uninsured." However, this debate actually proved to be

positive for safety net hospitals, in that it gave legislators an opportunity to state clearly that Medicare, along with all other payors, **does have a continued role in sharing the burden of financing care for low income patients, and the specialized services offered by safety net hospitals**, -- at least until such time as our nation achieves universal health coverage.

1991 saw a significant effort to recoup past direct medical education payments **by changing reimbursement rules and then attempting to apply those changes retroactively.** HCFA's major efforts last year to audit GME payments on the basis of regulations adopted in 1989 are based on Federal legislation adopted by the Congress in 1985. However, we are concerned that the HCFA regulations and audits differ in several major ways from the original statutory intent, and further, with the retroactive application of 1989 regulations to cost reports dating all the way back to 1984. We are pleased and grateful that the Congress, with the leadership of this Committee, intervened in OBRA 1990 to slow down HCFA's recoupment effort. We are concerned that considerable additional vigilance in this area will be called for on your part this year, and we hope to work with you closely on this important matter.

A New National Capital Financing Initiative Is Needed To Rebuild And Equip America's Institutional Health Safety.

Safety net hospitals also face a substantial need for adequate capital to rebuild and equip our nation's health infrastructure. A new NAPH study, which I have submitted to your staff, estimates that there are at least $15 billion in unmet capital needs among these essential urban providers. Yet these hospitals also face significant barriers in obtaining access to capital, as well as in their ability to repay incurred debts entirely from patient care revenues. In order to meet these needs, a new Federal capital financing initiative is clearly needed. Options for such an initiative might include direct federal grants and loans, debt service subsidies, and credit enhancements such as mortgage or bond insurance. While we do not envision such a program directly involving Medicare capital payments, it may be possible to draw upon the financial strength of the Medicare trust fund to enhance the credit of safety net hospitals. Eligibility for such a new program should clearly involve a high standard of need in urban and rural areas, and hospitals accepting assistance should probably also be willing to meet long-term indigent care and community service requirements, and perhaps other reporting and utilization requirements. We look forward to working with this Subcommittee to develop some appropriate options in this area.

Most assuredly, we do not lack for resources to increase health coverage and implement other needed health system reforms. All we need is a commitment to devote a small proportion of our nation's projected **future increased health spending** to filling coverage gaps and meeting unmet needs. This is something we should easily be able to accomplish if we can simply bring some greater governmental and private sector discipline to the way our resources are currently spent. On behalf of the governmental and private entities that comprise NAPH, we are pleased to offer you our partnership and support in this effort.

I would be happy to answer any questions you may have at this time.

Chairman STARK. Thank you very much.
Karen.

STATEMENT OF KAREN DAVIS, PH.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, SCHOOL OF HYGIENE AND PUBLIC HEALTH, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD.

Ms. DAVIS. Thank you, Mr. Chairman and members of the committee, for this opportunity to testify on issues of financing health care for the poor and a national health insurance system. I compliment the leadership of this committee in trying to design a plan to provide universal health insurance coverage for all Americans.

I would like to focus today primarily on the lessons that we can learn from the Medicare and especially the Medicaid programs. This committee is aware of the important contributions Medicare has made to improving access to care for the elderly, improving the quality of life for the elderly, and providing financial protections for the elderly and their families from high bills.

The same is true with Medicaid. Medicaid covers 24 million low-income individuals. It has helped improve access to care and helped get infants off to a healthy start in life. Most of us think of Medicaid as a program for poor pregnant women and children, but three-fourths of the money goes for the elderly and disabled. Medicaid buys Medicare for the poor, elderly, and disabled, pays the premiums, deductibles, and cost-sharing. It also covers many disabled groups—for example, the mentally retarded, 40 percent of people with AIDS are covered by Medicaid. It picks up many long-term care expenses that are not covered by Medicare for the frail, elderly, and disabled.

Both Medicare and Medicaid have a good record of lower administrative costs and increasingly a good record of cost containment. With the new Medicare physician payment reform, we should show remarkable progress in slowing the growth of Medicare outlays. Medicaid, despite the fact that it covers very sick people, averages costs that are comparable to per capita spending on health care for all Americans.

Despite those accomplishments, though, I would like to highlight four lessons, particularly from the experience with Medicaid that I think are troubling and need to be kept in mind as we design a national health insurance plan.

First, Medicaid benefits are inequitably distributed by geographic location. Medicare covers the same benefits and has the same eligibility criteria for everyone. But under Medicaid each State has a lot of leeway to set who is eligible and what is covered. As a result, Medicaid has widely different benefit levels from State to State. There are restrictions on covered benefits. Income eligibility may be set at 15 percent of poverty in a State like Alabama and 78 percent of poverty in a State like California.

The Federal Government is using its money to cover a poor family with a income of $6,000 in one State but won't help pay their medical bills in another State.

Payment rates to physicians are set by the States, and they vary enormously from one State to another but are typically well below Medicare levels.

The second lesson I think from this experience is that Medicaid's performance in general as a health insurance plan has been inadequate, certainly much less so than Medicare. It sets limits on benefits. It has inadequate provider payment rates. It hasn't indexed eligibility with inflation, nor has it tended to index increases in provider payment rates with inflation.

There have been attempts to propose rationing care for Medicaid beneficiaries, for example, in Oregon. You don't see those kinds of proposals for the aged or for privately insured persons. Medicaid programs have tried managed care, often with very poor results. Administration of Medicaid data systems, and management information systems, have generally been inadequate.

The third major lesson I think from the Medicaid experience is that States have a very uneven fiscal capacity to fund health services for the poor. While the Federal matching rate varies from State to State depending upon the per-capita income, it has not been enough to help poor States be able to afford adequate coverage for the poor.

Finally, State fiscal capacity is very vulnerable to changing economic conditions. Over the 25 years of Medicaid, every time there has been a recession there has been a crisis in the Medicaid program. States just can't afford the outlays at a time when recession is increasing the cost of unemployment compensation and reducing sales tax revenues.

In general, I would note that State tax revenues are more regressive than Federal general tax revenues and tend typically to rely more heavily, for example, on sales taxes.

I think those lessons are important as we think about designing national health insurance. Any national health insurance plan will have to decide what to do with Medicare and Medicaid—whether to keep them, replace them, modify them, build upon them. There have been proposals, for example, like Mr. Russo's, that would replace Medicare and Medicaid with a universal comprehensive public plan covering everyone. Obviously then you don't have some of these problems, but that also requires using Federal money to replace what States are currently spending, almost $70 billion on health care.

Another option which some have supported is to keep Medicaid as a Federal-State program and expand it to cover all of the poor. Under such a plan these problems that I have pointed out would continue.

Another proposal would be to replace Medicaid with a new Federal-State program—give it a new name and try to cover some more people under it. Enormous variations across States in such areas as provider payment and potentially benefit levels, however, are likely to continue.

One could also replace Medicaid with a new Federal program which would have uniform benefits and eligibility, and, again, let employers, for example, buy that coverage for their workers.

Finally, one could simply build on Medicare as a national health insurance plan, either by covering everyone under Medicare, or by

letting employers buy Medicare or private insurance and letting States buy Medicaid beneficiaries into Medicare. Currently, States buy Medicare coverage for the poor elderly and disabled. States should also be permitted to buy low-income families into Medicare, paying their premiums and deductibles and cost-sharing and supplemental benefits, like prescription drugs, the way they do now with Medicare elderly and disabled low-income people.

All of these options deserve careful consideration and debate. I congratulate the committee on this hearing that addresses this central issue about what to do about low-income Americans in the design of a national health care plan.

Thank you.

[The prepared statement follows:]

LESSONS OF MEDICARE AND MEDICAID
FOR NATIONAL HEALTH INSURANCE

Karen Davis

Thank you, Mr. Chairman, for this opportunity to testify on lessons that can be drawn from the Medicare and Medicaid experience in designing national health insurance options for the nation. The leadership of this Committee in designing a plan to provide universal health insurance coverage for all Americans is a critical contribution at a time when 33 million Americans are falling through the cracks of our patchwork system of public and private coverage. The deterioration in access to needed health care services for uninsured Americans that has occurred in the last ten years is a national tragedy and urgently needs action.

In designing a plan for all Americans we can learn a great deal from 25 years of experience with the Medicare and Medicaid programs. Today, these two programs cover almost 55 million Americans, and spend $207 billion in fiscal year 1991, or about 27 percent of all national health expenditures.

Today, I would like to review briefly the major accomplishments of Medicare and Medicaid, outline four major lessons I believe we have learned from this experience, and comment on options for building on the Medicare and Medicaid programs as a foundation for a national health insurance plans.

Accomplishments of Medicare and Medicaid

This Committee is well aware of the many accomplishments of the Medicare and Medicaid programs but I would like to highlight those briefly for the Committee.

First, without Medicare and Medicaid the failure of this nation to enact a national health insurance plan would have been an even greater national disgrace. Medicare covers nearly all of our nations 30 million elderly Americans -- most of whom lost private health insurance coverage when they retired. Before Medicare was enacted any episode of serious illness or injury threatened to bankrupt the elderly and their children.

Medicaid supplements Medicare for the low-income elderly and long-term disabled. Despite the impression that Medicaid is a program for low-income mothers and children, almost three-fourths of all Medicaid outlays go for care of the elderly and disabled. Medicaid pays the Medicare premiums and cost-sharing for poor Medicare beneficiaries. It covers prescription drugs, long-term care, and other services not covered by Medicare. It also covers many disabled not covered by Medicare. Facilities for the mentally retarded, for example, represent 12 percent of all Medicaid outlays. Forty percent of all persons with AIDS are covered by Medicaid, compared with only about one percent covered by Medicare -- and three million permanently disabled persons. Medicaid outlays for the disabled are the most rapidly increasing component of the program.

Both Medicare and Medicaid have improved access to health care services for some of nation's most vulnerable citizens. Without Medicare there is no question that millions of elderly Americans would be driven into poverty by medical care bills. We often credit improvements in Social Security with reducing poverty among older people, but Medicare also deserves a large share of the credit. Medicare has contributed to lengthening life expectancy of older Americans, and improved the quality of

life for Medicare beneficiaries by providing access to such services as cataract surgery and hip replacement that greatly improve the functioning of older people.

Medicaid, similarly has helped keep families from utter destitution as a result of medical care bills and has enabled low-income Americans to obtain needed health care. It has contributed to reductions in infant mortality, and helped poor children get off to a healthy start in life. It has improved use of preventive care such as prenatal care and immunizations. It has helped keep the doors open of many hospitals and health centers serving the poor that would have been forced into financial failure without at least some insurance coverage for their patients.

Both Medicare and Medicaid have kept administrative costs quite low -- less than 3 percent of benefit payments. This record has been achieved despite the seriousness and complexity of the health problems of their beneficiaries.

Medicare has a good record in recent years in slowing the rate of increase in hospital outlays. The new Medicare physician payment reforms should be similarily successful in future years. Medicaid, while covering some of our nations most frail and disabled people, has costs that are comparable to the average national health expenditure per capita. Per capita expenditures under Medicaid of $2300 in 1989 are slightly below national per capita expenditures of $2400 for the entire U.S. population -- despite the fact that Medicaid serves a disproportionately sick and disabled population.

Medicare, and to a lesser extent Medicaid, have gained acceptance as essential sources of financing health care well-known by beneficiaries and providers.

Lessons of Medicare and Medicaid

Despite this record of achievement there is no question that Medicare has been subjected to far fewer problems than those experienced by Medicaid. In my view Medicaid's problems are rooted in its nature as a program only for low-income people and in the federal-state nature of the program. I think we can draw the following four lessons from the comparative performance of Medicare and Medicaid:

1. Medicaid benefits are inequitably distributed by geographic location.

Medicaid expenditures per beneficiary range from $1168 in Mississippi in 1989 to $4523 in New York -- a four-fold difference. By contrast Medicare reimbursement per person served ranged from $2323 in South Dakota to $3843 in California in 1988 -- a 65 percent variation and considerably less when adjusted for the cost of providing health care in different geographic regions. Medicaid variation reflects in large part the variation in covered benefits, limits placed on amount, duration, and scope of even basic benefits such as hospital and physician services, mix of covered beneficiaries, and varying provider payment rates. For example, all states cover prescription drugs, but only about half of the states cover preventive services for adults. By contrast Medicare's benefit package is uniform nationally, and no arbitrary limits on covered benefits for basic services such as hospital and physician services are imposed.

Maximum AFDC income for Medicaid eligibility varies from 15 percent of poverty in Alabama and Mississippi to 78 percent in California. Thirty-four states set income eligibility levels below 50 percent of poverty. Forty states provide Medicaid to at least some groups of medically needy persons. By contrast

Medicare covers the elderly and disabled according to the same eligibility criteria nationwide.

Medicaid payments to physicians as a percent of Medicare prevailing charges for an intermediate office visit range from 35 percent in New York to 118 percent in Indiana. On average Medicaid pays physicians 69 percent of Medicare rates. The wide variation in Medicaid payment rates for physicians, and clearly substandard rates of payment in some states, are a major reason why physicians fail to participate in Medicaid. By contrast under the new Medicare Fee Schedule physician fees will vary geographically only as a result of differences in the cost of practice. Provider participation in Medicare remains high ensuring adequate access to health care services for Medicare beneficiaries.

2. Medicaid's performance as a health insurance plan has been inadequate.

In addition to the wide variation among states, in general Medicaid has performed poorly as a basic health insurance plan for covered beneficiaries. These deficiencies include the above-cited inadequate benefits, arbitrary limits on basic benefits that prevent the chronically ill from obtaining necessary care, and inadequate provider payment rates and participation. There is no rationale for variation in benefits, eligibility, lower provider payment, or for using federal funds to provide care to Medicaid beneficiaries that is below Medicare's standards.

But as a program for the poor, Medicaid seems especially vulnerable to substandard care. The state of Oregon, for example, is proposing to ration care for Medicaid beneficiaries but not for the aged or for privately insured persons.

State Medicaid programs have instituted a variety of managed care schemes -- with more often than not very poor results. One study, for example, found that the poor had worse health outcomes when enrolled in an HMO. This problem is particularly serious in states that give Medicaid beneficiaries little choice but to enroll in a managed care plan regardless of the quality or adequacy of care. By contrast Medicare has been careful to ensure beneficiary choice of provider. Its experience with HMOs has been modest and on the whole has maintained sufficient quality of care standards.

Medicare has been more innovative in designing provider payment systems that encourage hospitals and physicians to provide care efficiently, while Medicaid has simply held down payment rates as a cost containment approach. Medicaid, on the other hand, has been slightly quicker to recognize the importance of covering preventive care, at least for children.

The administration of Medicaid has been lacking. It is impossible to know nationally with any accuracy, for example, how many poor pregnant women are covered by Medicaid, how many Medicaid children are immunized, what proportion of eligible people enroll, and what the cost of care is for people with different disabilities such as AIDS. The Health Care Financing Administration has treated Medicaid as a step-child with inadequate funding for research and data systems that would help improve the program.

3. States have an uneven fiscal capacity to fund health services for the poor.

In part the wide variation in Medicaid performance across states reflects the variability in political support for a program that finances health services for the poor. But in part it reflects the wide variation in state fiscal capacity. Even with federal financial matching rates that favor states with low

per capita incomes ranging from 83 percent for the poorest states to 50 percent for the richest states. A recent analysis by Stephen Long of the Rand Corporation finds that the 20 lowest income states had 33 percent of the poverty population but received only 20 percent of Medicaid benefits. Poor states are simply unable to afford adequate health care coverage for the poor.

4. State fiscal capacity is very vulnerable to changing economic conditions.

Over the 25 years of its history state Medicaid programs have encountered a crisis whenever a recession has hit. States are especially vulnerable to changing economic conditions. In a recession revenues from sales taxes and income taxes decline, while expenditures for unemployment compensation, welfare, and Medicaid increase. The federal government, at least in the past has accepted, that it bears a counter-cyclical responsibility to stimulate the economy in a recession even if it means running deficits in recessions and (at one point!) surpluses in boom years. The federal government is able to assume this role because it does not operate subject to the same balanced budget restrictions as many states.

This cyclical problem of states is apparently compounded by trends over the last decade to reduce federal support to states and for states to lock themselves into lower tax rates through state tax propositions.

Although states use a variety of tax sources, in general state taxes are more regressive than federal general tax revenues which are largely based on a moderately progressive personal and corporate income tax system.

These fiscal problems of states make it very difficult to turn to states for primary leadership in financing health care for the nation's poor and uninsured.

Implications for National Health Insurance Options

Any national health insurance plan will need to deal with the issue of the continuation, elimination, replacement, or modification of the existing Medicare and Medicaid programs. Since almost 30 percent of the uninsured are poor, and another 30 percent have incomes between the poverty level and twice the poverty level special attention will need to be given to how the special problems of low-income persons are addressed. Options include:

- Replace Medicare and Medicaid with a universal comprehensive public national health insurance plan.

  A public plan that covers the entire population with a comprehensive benefit package with no cost-sharing would eliminate most of the problems discussed above. However, it would require massive new federal outlays, to replace private health insurance outlays, out-of-pocket spending by patients, and the current state outlays of about $70 billion spent on health care.

- Keep Medicaid as a federal-state program and expand it to cover all of the poor.

  This approach would eliminate gaps in health insurance coverage and reduce variability among the states in eligibility but retain virtually all of the other problems noted above.

- Replace Medicaid with a new federal-state program and expand it to cover state employees, small business, and the poor and near-poor uninsured.

  This approach would attempt to eliminate the welfare image of Medicaid by giving it a new name and broadening the base of eligibility to include some middle-income or at least lower-income working families. Some greater uniformity of covered benefits and eligibility standards for low-income subsidies would be achieved. However, provider participation is likely to be low so long as states determine provider payment rates and the program is unlikely to be attractive to most employer groups.

- Replace Medicaid with a new federal program and expand it to include employer groups opting to "pay" for public coverage of workers and dependents.

  This, in my view, is greatly preferable to retaining the federal-state nature of Medicaid. However, by assuming total federal fiscal responsibility for low-income subsidies to the poor, federal outlays would need to increase substantially. In addition, since long-term care represents 45 percent of Medicaid outlays decisions will need to be made on whether to retain a residual Medicaid program for non-covered benefits.

- Build on Medicare as the basis for a national health insurance plan.

  This, in my view, is a very attractive option. It builds on the proven strength and record of the Medicare program. It guarantees continuity of coverage, so that the poor do not have to change coverage when they leave welfare or change jobs. It has greater uniformity and simplicity. It has an approach to provider payment that encourages efficiency and through Medicare's new volume performance standards ultimately controls total outlays for health care spending. It is progressively financed.

  There are two options within this approach: cover everyone under Medicare or give employers the choice of buying Medicare or private insurance. Under either approach a limited role for states could be retained by having states buy low-income beneficiaries into Medicare as they do now for poor elderly and disabled dual beneficiaries. State Medicaid programs would pay premiums, deductibles, and coinsurance for any poor Medicare beneficiaries. State Medicaid programs would provide supplemental benefits such as prescription drugs. State Medicaid programs would continue to finance long-term care until Medicare benefits were expanded to cover home care and nursing home care on a social insurance basis. Even with such coverage Medicaid would have a role in picking up any long-term care deductibles and coinsurance for the poor.

  One of the principal advantages of this option is that it keeps some state fiscal contribution to coverage, reducing the need for federal outlays. It also retains state administrative capacity to determine income-tested eligibility subject to uniform national standards.

However, benefits and provider payment would be uniform and administered by Medicare. Economies of scale from claims processing by intermediaries and carriers could be realized. Eligibility for low-income subsidies could be tied to national poverty rates, such as complete coverage for persons below poverty and sliding scale coverage for persons between poverty and twice the federal poverty income level.

All of these options deserve careful consideration and debate. I congratulate the Committee on this hearing which focuses on one central issue in the design of any national health insurance option -- namely assuring coverage of the poorest and most vulnerable Americans.

Chairman STARK. Thank you.
Dr. Freund, proceed.

STATEMENT OF DEBORAH A. FREUND, PH.D., PROFESSOR OF HEALTH ECONOMICS, SCHOOL OF PUBLIC AND ENVIRONMENTAL AFFAIRS, INDIANA UNIVERSITY, BLOOMINGTON, IND.

Ms. FREUND. Thank you very much, Mr. Stark, Mr. Coyne, and other Representatives in absentia. I thank you for inviting me here today.

I am Deborah Freund. I have a variety of titles at Indiana University, which you can read in my testimony.

I want to change focuses from the previous speaker and in particular talk about those people who currently are eligible for Medicaid and that proportion of the uninsured who are poor and not working. In particular, I have suggestions regarding how the delivery system for the poor should be reorganized to improve health care, the health outcomes of the poor, and be more cost effective. Whether we go to a universal system or not, my concern is that guaranteed access doesn't bring us what I think is another concern, and that is better health status and better ability to perform in the economy.

Currently we spent billions of dollars on social programs from a variety of sources, each with similar objectives. But if they were reorganized, we could get more bang for the buck. Any solutions to our indigent care problems must recognize that individuals who are poor face a complex and tightly intertwined web of problems that must be addressed in a variety of ways, not only through health insurance. And unless we tackle the problem realizing that, I don't think we will get anywhere.

In addition to lacking good access to care, the poor or homeless, they lack job skills, adequate housing, and nutrition. So do their families. Currently, coordination among programs designed to redress the problems of poverty and poor health are virtually nonexistent.

For example, a study in Wayne County in Fort Wayne, Ind., near where I live, showed that individuals who get prenatal care through Medicaid never make it to the WIC office. And so when they give birth to babies, they still give birth to low birth weight babies, and that in some ways doesn't allow us to achieve what health insurance is supposed to do to begin with.

Lessons from 10 years of my studies of Medicaid case management provide a framework for discussing what might happen if the system for providing social programs is changed. For those of you who may not be familiar, under Medicaid case management, Medicaid programs contract for the delivery of services with primary care physicians as case managers or with prepaid organizations like HMOs. Their case managers are required to deliver all needed primary care and prior authorized all needed services in return for which they are reimbursed fee for service, plus a case management fee of about $3 per enrollee per month.

Medicaid recipients are required to select a gatekeeper or a prepaid plan, and they are guaranteed access. My evaluations of others of over 25 of these programs suggests that under case man-

agement quality of care is maintained, doctor shopping is reduced, and cost is lessened 5 to 15 percent, depending on how it is done.

Now, how do these cost savings come about? They come about through reductions in unnecessary hospital care and through an increase in continuity of care which gets rid of doctor shopping through case management.

What I would like to suggest is, whatever we do, we reorganize services by expanding the case manager concept to a greater variety and array of social programs. What I have in mind is a one-stop shopping center to be located near where most of the poor reside and convenient to public transportation, not in several places. It would be open evenings and on weekends, which is essential because individuals who are poor have other things to do during the day which keeps them away from primary care physicians even if they are willing to take them. You could have volunteer groups in the similar space.

Caseworkers or case managers would be at the shopping center and be expert on all programs that serve the poor. I would like to have one integrated management information system and to heck with the 10 that currently exist if you want to access all of them together.

Anyone in need of services would walk into this shopping center, choose a case manager who would be responsible for coordinating all needed services. This would eliminate the excessive number of interviews and numerous case managers to whom the poor are now subjected, and greatly streamline the system.

I often hear complaints that go like this, and I hang out in welfare offices:

I am sick of telling my story so many times to everyone in the world. It is embarrassing and demeaning. Why can't I tell it once?

At the present time, Departments such as Health and Human Services and Housing and Urban Development, as well as private foundations, are experimenting with models of coordinated social program delivery. Lest I leave you concerned, I am talking about ones for housing, for day care, for jobs as well as for Medicaid. However, rarely can you access them in one place, and if you can't access them in one place, you don't get all of the things together addressing health.

What is more disturbing is that these individuals and institutions responsible for the programs don't communicate with managers of other related programs. There is no guarantee that the best programs and most important lessons are being shared, and so we have a delivery system which is incredibly inefficient.

I urge that no matter what you do, you realize that the system we have is not oriented toward better health for the poor but detracts from it.

Thank you.

[The prepared statement follows:]

Testimony of Deborah A. Freund before the Subcommittee on Health of the Committee on Ways and Means, June 27, 1991

Mr. Stark and distinguished Representatives, I thank you for inviting me here today. My name is Deborah Freund. I am a professor of health economics in the School of Public and Environmental Affairs at Indiana University. I am also director of the Health Services Research and Bowen Research Centers and hold appointments in The School of Medicine and the Department of Economics. My remarks are based on ten years of research into the medicaid program and represent my own opinions not those of Indiana University.

I will focus my remarks today on Medicaid and that proportion of the thirty-seven million uninsured Americans who are poor, do not work and do not qualify for Medicaid. In particular, I have suggestions regarding how the delivery system for the poor should be reorganized to improve health care, health outcomes, and be more cost effective. Whether or not we move to a system of universal insurance, better organization of existing services is essential if each service is to be of maximum benefit. We spend billions of dollars on social programs with similar objectives each year, but these dollars could be spread much farther (be more cost effectively utilized) if some changes were made.

Any solutions to our indigent care problems must recognize that individuals who are poor face a complex and tightly intertwined web of problems that cannot be addressed by providing health insurance or medical care alone. In addition to lacking good access to medical care, the poor often are homeless, lack job skills, adequate housing and nutrition. Their children and families face similar problems. Currently, coordination among programs designed to redress the problems of poverty and poor health are virtually nonexistent. For example, a study in Fort Wayne Indiana suggests that many poor women who obtain prenatal care never visit a WIC program to receive counselling or additional food[1]. In a recent article, Carey et al. reported that birth outcomes and the proportion of women getting care in the first trimester were no better in a group of women with guaranteed access to care than for pregnant women without guaranteed access[2]. Apparently, other variables besides access affect the propensity to seek care and the resulting birth outcomes.

Lessons from ten years of studying Medicaid case management initiatives around the United States provide a framework for discussing what might happen if the system for providing social programs is changed. Under Medicaid case management, state Medicaid programs contract for the delivery of services with primary care physicians as gatekeepers/case managers or with prepaid organizations such as health maintenance organizations. Case managers are required to deliver all needed primary care and prior authorize all needed services in return for which they are reimbursed fee-for-service plus a small case management fee of about $3/enrollee/month. Medicaid recipients are required to select a gatekeeper or prepaid plan thereby being guaranteed access to medical care.

Evaluation of over 25 Medicaid case management programs by Freund, Hurley and others[3] suggests that under case management, quality of care is maintained, doctor shopping is reduced and cost lessened by 5-15% depending on the model used and the number enrolled. Reductions in expenditures and changes in doctor shopping behaviors are achieved through moderate reductions in hospital use, dramatic changes in unnecessary use of the emergency room and a measurable increase in the continuity and coordination of care by the primary care gatekeeper. Undoubtedly greater improvements in the health of the poor would have occurred had a Medicaid case management system

been coordinated with other social programs that improve housing and day care. For example, Medicaid case management reduced unnecessary emergency use by providing twenty-four hour access to a primary care physician. Under standard Medicaid unnecessary emergency department use exists not only because primary care physicians are not available during the day and night but also because Medicaid beneficiaries have other needs that can only be accommodated during the day.

I suggest expanding the case manager concept to a greater array of programs. I have in mind a "one-stop" shopping center to be located near where those most in need reside and convenient to public transportation. It would be open in the evenings and on weekends. All of the important social programs, such as WIC, welfare, food stamps, low-income housing, and Medicaid would have offices in the shopping center. Volunteer groups could also be offered space as they have been documented to represent an important source of services in some communities[4]. Case managers/caseworkers would be at the shopping center and be expert on all programs that serve the poor. Anyone in need of services would walk into the mall and choose a case manager who would be responsible for coordinating all needed services for which they were eligible. This would eliminate the excessive number of interviews and numerous case managers to whom the poor are subjected now and greatly streamline the system of social program administration. I often hear complaints about "telling my story too many times to everyone in the world. Why can't I tell it once." One-stop shopping would undoubtedly lead to greater and better use of valuable social resources. It is more likely that complementary social services would be obtained, and medical care would more likely have maximum impact. The funds saved through efficiency in administration could be used to extend services to greater numbers of people.

At the present time, departments such as Health and Human Services and Housing and Urban Development[5] as well as private foundations are experimenting with models of coordinated social program delivery. Rarely are all the pieces in place. What is even more disturbing is that the individuals and institutions responsible for individual programs do not communicate with managers of other related programs. There is no guarantee that the best programs and most important lessons are being shared. As a concerned citizen, health services researcher, and board member of the Association for Health Services Research, I urge serious evaluation and consideration be given to coordinating and integrating the delivery of essential social services to the poor.

1.David Weinschrott, Hudson Institute, personal communication, June 20, 1991.

2.Carey,Timothy S., Kathi Weis, and Charles Homer, "Prepaid versus Traditional Medicaid Plans: Lack of Effect on Pregnancy Outcomes and Prenatal Care," Health Services Research, Vol. 26, no. 2, 1991, pp. 165-181.

3. Freund, Deborah A., et. al.,"Nationwide Evaluation of Medicaid Competition Demonstrations", Health Care Financing Review, Vol. 11, no. 2, 1990, pp. 81-97

Hurley, Robert, et. al.," Emergency Use and Primary Care Case Management:Evidence from Four Prepaid Medicaid Programs," American Journal of Public Health, vol.79, no.7, July 1989, pp.843-47.

----------," Gatekeeping the Emergency Room: Impact of a Medicaid Primary Care Case Management Program",Health Care Management Review, vol. 14.,no. 2, Spring, 1989, pp. 63-72.

Hurley, Robert and Deborah Freund, Primary Care Case Management Evidence from Medicaid:synthesizing Program Effects by Program Design, HCFA cooperative agreement 18-C-99490/3-01 (draft)

4. Rosentraub, Mark, et.al. "Providing and Producing Indigent Health Care: Volunteerism, Communities and a Federalistic Perspective", Annual Meeting of Urban Affairs Association, April 17-21 1991, Vancouver, B.C.

5. For a description of operation bootstrap funded by HUD see Federal Register, vol. 54, No. 125, Friday, June 30, 1989.

Chairman STARK. Thank you.

Mr. Coyne.

Mr. COYNE. I have no questions.

Chairman STARK. Do we complicate the system or simplify it by separating acute care from nursing home or long-term care? It seems to me these are two separate problems. One is not really related to medical care; long-term care being largely an income issue. A nursing home costs $3,000 a month. If you have got $3,000 a month, you are OK. If you don't, you can't get it.

They say that 80 percent of the people who need long-term care really don't need any higher level of medical care than they would otherwise. So that if we separate them, you are dealing with a smaller piece of the whole pie and somewhat different provider populations.

Does anybody have any comment on this? Is there any reason we have to keep this linked together?

Ms. DAVIS. Certainly what we have done so far has separated them to some extent in that it has been Medicaid that has largely picked up the nursing home bills. I think there are some arguments for dealing with the acute care problem first, the problem of the 34 million uninsured who do not have any basic health insurance coverage. But I think we are going to have to deal with long-term care, and then the issue is: Does it remain in a separate program such as Medicaid? Does it become a social insurance program such as the expanded benefits under Medicare?

One argument for trying to keep them together over the long term is that, in fact, nursing home patients make a lot use of hospital and physician services. We tend to think they are in the nursing home and they stay there, but they are in and out of the hospital. They have chronic conditions that hospitalize them.

Chairman STARK. But don't you suspect that we are doing that before they became a resident in the nursing home, or if they had some family member or a care giver at home that they would still be doing that? That is the sense that I get.

Ms. DAVIS. I think it is also the case that the functionally impaired who are able to stay at home are also heavy users of hospital and physician services. But I just think there are some innovations in, say, looking at a comprehensive way of paying for long-term care and acute care that would recognize that the same person has a continuum of needs. And so I am a little uncomfortable with permanently segregating acute and long-term care.

Mr. EIZENSTAT. If I may just add to that, Mr. Chairman, I think that in terms of financing, it is worthwhile looking at the two differently. For example, for acute care to cover the 34 million uninsured, one can look at employer mandates, and expanded Medicaid programs which could mandate the States to cover a minimum package. The real increase in the cost of Medicaid is coming in long-term care and that is something that could be federalized.

Chairman STARK. That is what the States want. I mean the States want us to pick up the long-term care, and they want to pay for the acute care. For instance, in California, that's just where our good Governor is lousing up the system. Nursing homes aren't doing so bad, but he is paying physicians only one-third of their normal fees. Even I would have to take the physician's side on that

instance, and say, I don't blame them for not filling their books with paying patients and not going to visit Highland Hospital for one-third of what they can get in private practice. That doesn't make any sense. I don't know. Do all three of you think that that's the way we should do it, that we should pick up the long-term care and let the States do the acute care?

Ms. DAVIS. I think that basically in the end we are probably going to have to federalize both. I don't think there is any indication that the States are running a quality program for low-income families under the age of 65 either. There are arbitrary limits on benefits for example, a pregnant woman goes off Medicaid coverage 60 days after she has delivered a baby.

Chairman STARK. But let's say its the perfect world according to Stark where we had universal access. My inclination would be to say; the hospitals end up going to global annual budgets—we run the fire department that way, we run the police department that way, we run the schools that way, and the Defense Department that way. Now, arguably there would be a huge political battle each year as to whether or not we have enough defense, enough police on the streets, or taxpayers are paying too much. Some cities go bankrupt, not many, but if you left that to the community they would have to decide what they could afford and what they would tolerate and we might have to subsidize it but it just seems to me that we could do that.

Ms. FREUND. Well, one thing that is nice about that is that it places the incentive to use the lowest level of care possible. My concern about the fragmented system we have now is that it is not necessarily the case. I want to get back to some of the points that I made.

Chairman STARK. The lowest level of care possible or——

Ms. FREUND. That's necessary to the patient. If you have two strains——

Chairman STARK. The lowest level we have now is the Republican suggestion of no care. I mean that is as low as you can get.

Ms. FREUND. Well, I am suggesting needed care. I would never sit before you and suggest that if somebody needs some sort of long-term care that they go without, but what I am suggesting is that the two streams you have now tend to bureaucratize the system and everybody looks out for themselves. Whereas if you had one stream that came through a global budget or whatever, other creative way you had, then the incentive would be to spread those dollars as far as you could go. And if the person would be best left with intensive day care at home, then that's what they would have and they would not be in a nursing home simply because Medicaid paid for it.

Ms. DAVIS. I think the global budget idea has a lot of appeal but I think we ought to look at what's working now. What is really working now is the Medicare program. Medicare has a good system, for paying hospitals and physicians.

Chairman STARK. Medicare, oh, yes, no question.

Ms. DAVIS. It has got a good system of paying hospitals on a diagnostic per case basis. It now has a good fee schedule system for paying physicians.

Chairman STARK. That's what I would start with on the acute care side immediately.

Ms. DAVIS. Moving Medicaid to that system and, perhaps moving people on private insurance to that system would also help.

Chairman STARK. Government employees.

Ms. DAVIS. Right.

Chairman STARK. Congressman Ford watch out. But seriously, if I think Medicare is so good and I do, would I be willing to take it instead of what I have now, Blue Cross low-option? Yes.

Then I would buy in effect a medigap policy offered by a variety of unions or insurance companies but keep the base plan for Federal employees. It would probably save the taxpayer some money and arguably we would get as good insurance as we have now. To subsume Medicaid into Medicare would seem to me to be a slam-dunk. I don't know that you would have to really change a thing—you could make just eligibility, I suppose, through the tax system.

So there is no application form, there is no line at the welfare office, it is on your tax return.

Mr. EIZENSTAT. The reason that I was talking about trying to separate the payments is not because I disagree with Karen in any way, but ultimately they may have to be federalized. But I think that if you put a package up that is too expensive, it may be very difficult to pay and I would rather make a first step, Mr. Chairman, and have States mandated to provide some sort of median package, eliminate some of the variations in eligibility levels and take that as a first step before trying to federalize the whole package.

Chairman STARK. Yes, we are going to have to bail out some of the States, like Arkansas, Alabama, and Mississippi. The rich States like New York and California, and its residents are going to have to swallow hard and say, if this is a Federal program, then we ought to pay for it. I mean that is going to be politically the tough one.

Mr. McDermott, did you wish to get into the fray here?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I only had one question as I was reading the statements by Dr. Davis and Dr. Freund, I find statements in yours, Dr. Davis, that managed care is not very useful, that quality of care goes down. Dr. Freund says that she looked at 25 Medicaid case management programs and finds that quality of care is maintained, doctor shopping is reduced, and the cost is lessened. I know that you may have been talking a little bit at odds to one another, but could you explain where the differences seems to be?

Ms. DAVIS. I am trying to raise some cautions about managed care as a panacea for Medicaid. I think we are talking perhaps about slightly different meanings of managed care. I am focusing specifically on capitated plans and not the use of the case management approach to coordinating services. But, for example, one study found that when low-income persons were enrolled in a health maintenance organization, in the State of Washington, that the health outcome was worse than if they had free choice of provider, and no financial barriers to care. So it is at least troubling that maybe the poor are not as able to insist on getting services when they need it in the capitated plan. A number of States have

tried various kinds of forcing beneficiaries, for example, to enroll in HMOs. The State of Wisconsin in Milwaukee and Madison within a 6-month period of time said that all AFDC/Medicaid families had to enroll in an HMO and tried to do it very rapidly. It had instances of very seriously disabled children, for example, with very high expenses, and yet, the HMO is supposed to be able to provide quality care for a fixed capitation rate. There were instances in that case of people who had been using emergency rooms perhaps inappropriately, but once that system went into place you would have people with children with high fevers being turned away from emergency rooms even though they needed emergency care. I just raise a caution about extending the HMO concept, denying freedom of choice to other providers in the Medicaid program. I think we have had some very bad experiences which is not to say that there are not some merits to the case management concept that Dr. Freund was alluding to.

Ms. FREUND. I am talking about something slightly different but I want to say that the problems with all of the statements about freedom of choice is that under the current Medicaid system we really have no way of knowing what is happening. There is no set of checks and balances. There is no normal set of grievance procedures you can count. So it is very hard to know that if under a Medicaid system which does contract with HMOs or does lock people in, whether in fact, they are worse off.

I think I have looked at this frankly more than anybody else and I want to tell you about two kinds of programs. There is one kind where enrollment with Medicaid in HMOs is mandatory. There are programs that are voluntary. Whether they are voluntary or mandatory the majority of them remain with fee for service reimbursements. And so that you don't have some of the scares that may come with capitated payment and when you look at those and you look at the most pervasive and well-done studies of quality of care you find no difference.

Now, that doesn't mean that the quality of care is wonderful to begin with, it is not, but it certainly is no worse. And you do find reductions in hospital utilization. We looked at all emergency room encounters in about 15 different places and found that there was a reduction in emergency room use, I will give you those citations and that the majority of it was a reduction in unnecessary care. So people are getting there and you want people to go to the emergency room when you really need it but you want them to go to a primary care physician as Mr. Eizenstat said when they have a runny nose. The reason I suggest the after hours kind of care and stuff that you can get with managed care is that if somebody has a fever at night, and you can go down to a place in your own neighborhood, not the local emergency room then you are in a situation where you can prescribe aspirin or an antibiotic or whatever that is $10 to $25 on the system, not $100 in the system.

So that you can in some sense have it all if you design it right and I think there are a lot of instances. At the same time——

Mr. MCDERMOTT. Tell me the perfect design in your mind?

Ms. FREUND. I think it would be a fee-for-service case management system that guaranteed everybody a primary care physician

and guaranteed them access to the other social services which tend to make the medical care they get more important.

The concern is, for example, if you take the case of prenatal care that everybody is fond of discussing, you can look at programs of guaranteed access and you will still see bad birth outcomes. They are not worse in the Washington study. What they found was not——

Mr. McDermott. Washington State?

Ms. Freund. The Washington State study that Karen Davis was discussing if I am thinking the right one which was the Bice study, there what they found was that it was more expensive to treat those people at first because they had health needs that when they came in were greater but birth outcomes after about a year of being in an HMO approached the same. So you have to give anything a startup period of time.

So I would have pretty much a fee for service case management system where you had a guaranteed primary care gatekeeper and I would like to see, I would like to really test out the idea of having it easy to get the other services too. It would be easy to have some place to put their kid, it would be easier to get WIC. If they were homeless it would be easier to get a house all at one place. Otherwise they are interviewed a million times, and that would be the same if you are talking about somebody who is not on Medicaid. Even if they go to indigent care programs which are funded other ways now, there is no guarantee that they are going to get the other things which are going to support that so that they are not going to take the medicines which are given, et cetera.

I just think that that is a crying shame because the money that is spent is not spent terribly wisely at the present time.

Mr. Eizenstat. Mr. Chairman, excuse me——

Mr. Levin. Mr. Eizenstat has to go.

Chairman Stark. Thank you, very much.

Stuart, as you leave I want to ask the question to the others that you have raised: why not simply make sure there is adequate reimbursement and a diminution in the variation among the States with Medicaid?

Mr. Eizenstat. Again that's not the perfect solution. To sell this politically so it is not so tremendously expensive that it blows away the proponents of national health insurance, that type of approach seems to me, at least on an interim basis, a way to begin. It's not the best. You want to ultimately have every poor person have the same level of coverage in every State. But if you mandated some minimum package up to a median level, and had the States pay for a substantial part of that, have the Federal Government federalize the long-term care piece, that that is at least a way of beginning the process that is, in some ways at least, politically more acceptable perhaps.

Mr. Levin. OK, goodbye, thanks.

So the others may comment. Karen, nice to see you again.

Why not do that?

Ms. Davis. I think that has a lot of merit. Currently Medicaid pays physicians about 64 percent of what Medicare pays physicians. You could obviously phase in better Medicaid physician payment rates in an incremental way, setting a floor that Medicaid

must pay at least 60 percent of the Medicare level in every State, then 70 percent and then 80 percent. So you could move gradually toward that and eliminate the worst problems where a State pays 35 percent of the Medicare fee for an office visit, for example.

So certainly one could deal with it, incrementally. In the long-term, there's a lot of merit to having the same payment rate for all patients under all systems, whether it's a low-income person, whether it's an elderly person, whether it's a working family, or where an employer is making a contribution to their health insurance coverage.

Chairman STARK. If the gentleman would yield? It happens that one of our distinguished colleagues has introduced a bill to do just that.

Mr. LEVIN. I know and there's a real problem with it, and that it arguably further shifts costs to the States. But the argument on the other side is that the failure of some States to implement a decent level of Medicaid is going to shift the cost to those States that do provide adequate Medicaid. And it may be a political problem, but I think there's a good question, why should residents of Pennsylvania have to pick up the default of residents of some other State?

And to simply say, well, it's better to federalize it, we're really talking in part, resources aren't we, not entirely? So what would be wrong with simply mandating, if it were politically feasible, mandating, at least as an interim step, a certain level of reimbursement by the States?

Ms. FREUND. Well, Mr. Levin, that would be a fine interim step, but I want to go back to the central point. That's all well and good, but if you spend a lot of time in the ghetto, as I have, with the numbers of studies I've done over 10 years, you come to the very compelling conclusion that there's a lot more going on out there besides just access problems.

And we have this whole panoply of other stuff going around that people don't have access to either.

Mr. LEVIN. I fully agree.

Ms. FREUND. And I would really like you to think about that. And just doing one thing is spending a lot more money and that's nice but it might not be cost-effectively spent either. And so I suggest that lots of things go hand-in-hand and it may be time to think about doing the hand-in-hand.

Mr. LEVIN. Well, all right, but you think where Medicaid is reimbursed 75 percent of Medicare the poor get better health care than where it's reimbursed 35 percent?

Ms. DAVIS. I think that is the case.

Mr. LEVIN. Let me, and then I was afraid that you were going to say, yes. So let me try and——

Ms. FREUND. It's very difficult to say. Because it really does depend a whole lot on the structure of the delivery system in the particular place. Clearly, if you pay more like Medicare pays or more like Blue Cross and other public payers pay you have more private physicians, for example, who are willing to see Medicaid patients.

But if they are in the suburbs, not in the inner city, then you have them participating at very low rates. So you can see that a

very high proportion of people participate but that they take one or two patients a year or a very small percentage of them. So that gets back to the point, I think once again, that doing that is a limited strategy. It's a very good strategy, but let's not oversell what it can accomplish.

Mr. LEVIN. I'm not overselling it, I'm just asking whether it's useful because I agree——

Ms. FREUND. I'm not debating that it's useful, I'm just saying that in my view it doesn't go far enough.

Mr. LEVIN. So, Karen, you think it would be a useful step?

Ms. DAVIS. I do think you get problems when a Medicaid program pays 35 percent of what Medicare does. In California, a woman might call 50 obstetricians to find somebody who would be willing to deliver her baby, because they just won't take them. But certainly the studies show that where the payment rate is very low, private physicians are just much less willing to participate in the program.

So there are very few private physicians that will take the Medicaid patients in those States. They have to rely on going to a hospital out-patient department or finding some source of care, and that means they are not going to have continuity of care, their physician is not going to know whether the kids have had their immunizations. They are going to be seeing someone different every time they go. This contributes to the problems that half of preschool children not being immunized in some areas.

It is part of the overall problem that Medicaid is more and more substandard by simply not keeping up with even the Medicare program.

Ms. FREUND. It definitely is the case, but I come from a State that if you can qualify, and it's very difficult, we have some of the highest payment rates in the United States relative to what other payers pay and the care is still concentrated in certain places. It's not distributed around like you would suggest would happen. There is a fairly high participation rate. We know this from a local study. There are still lots of primary care physicians out there, but they aren't in the places where we need them. So the market is not working perfectly to redistribute them, and the poor are not getting to all the people who might take them.

Mr. LEVIN. All right, of course, that isn't inconsistent with managed care trying to have a decent level of reimbursement?

Ms. FREUND. Right.

Mr. LEVIN. My time's up, thank you.

Chairman STARK. Any further inquiry?

[No response.]

Chairman STARK. I want to thank our panel very much and hope that we can make some small progress in the years ahead toward getting decent access to health care.

Ms. FREUND. Well, you have a big row to hoe but it's a very important topic.

Chairman STARK. Thanks a lot.

Our next witness is Ray Scheppach, executive director of the National Governors' Association. Welcome to the committee. Your written statement will be made a part of the record. Please proceed

to summarize or expand on your testimony any way you're comfortable.

STATEMENT OF RAYMOND C. SCHEPPACH, PH.D., EXECUTIVE DIRECTOR, NATIONAL GOVERNORS' ASSOCIATION

Mr. SCHEPPACH. Thank you, Mr. Chairman.

I'm pleased to be here today on behalf of the Nations Governors to talk about health care reform. The problems in the current health care system are clearly known—31 to 37 million Americans do not have health insurance; costs are virtually out of control, increasing at about twice or more the general CPI. This is creating major problems for both individuals and firms, particularly small firms. In addition the system is not very prevention oriented.

For States, the major problems have been in administering and financing the Medicaid program. It now serves 25 million people and has lost it's clearly defined purpose. We are essentially trying to provide core services to four distinct different populations. First, pregnant women and children with incomes below the AFDC levels; second, near-poor elderly, and chronically ill children for long-term care; third, the mentally ill and other disabled; and fourth, the poor elderly who are essentially under the Medicare program.

Medicaid grew 18 percent last year and is growing somewhere between 25 and 30 percent this year. On top of that it's not a prevention-oriented system and it is very cumbersome administratively. Overall it is not a very effective delivery system.

In a significant number of States, the growth in Medicaid, alone, is taking 80 to 90 percent of the discretionary change in revenues. For all of these reasons, Gov. Booth Gardner from Washington, the current chairman of NGA, appointed a 14-Governor task force last year to look at not only Medicaid, but the entire health care issue.

At our annual meeting August 18–20, the task force will produce both a detailed report on what States need to do to move forward, irrespective or what the Federal Government does; and second, a policy on what the Federal Government ought to do. One of the major elements they are looking at there, of course, is statewide prototypes to test a number of the reform strategies.

There is a feeling that although there's a national consensus that we need to change the system, there is not a consensus on the type of reform that, in fact, is necessary.

With respect to restructuring Medicaid, the Governors are looking at an option that would divide the current program into three major populations—first, the long-term care elderly over 65; second, the low-income poor; and third, the disabled population.

Essentially these three groups require different combinations of social service packages and health packages. It may be much more efficient to deliver those services if, in fact, there were three different programs.

It may be that the Federal Government should, in fact, take back the long-term care component and fund it 100 percent out of some broad-based tax. It could be that if the Federal Government were willing to do that, the States might be willing to exchange and pay for a higher share of the disabled portion, and also to expand the

low-income, or so-called residual Medicaid program for a higher percentage of the low-income individuals.

If we expanded that program it would also allow us the option to do buy-ins for people above that particular poverty level, also buy-ins for self-insured or self-employed people and for small business. So, it could, in fact, become a much more comprehensive program. I would have to stress that this is not current NGA policy; it will be considered with some other options in the summer.

There are several themes that have emerged in the Governors' discussions on comprehensive policy to restructure the U.S. health care system. In discussing these themes, I am not presenting policy again, but my own speculation on some of the overall directions.

First, the Governors must be major participants in any national consensus on health care reform. A significant number of the policy levers to reform this reside at the State level. For example, insurance reform, tort reform, licensing of doctors, regulation of hospitals all currently reside at the State level.

Chairman STARK. The insurance will disappear soon.

Mr. SCHEPPACH. Cost control and access are clearly linked. The failure to control health care costs in any reform will significantly reduce the possibility of enhancing access. The States' interest in cost control range from discrete strategies, like increased incentives for managed care to the more comprehensive innovative strategies like an all-payer or single-payer system.

While access and financing lend themselves to Federal policy it is likely that cost control and program administration of any new policy would likely be done at the State level. Because the current health care market is not competitive, Federal and State policy must drive it in one of two directions—either to make it much more competitive or to fully regulate the market. Fifth, the health care system must be more prevention oriented.

Thank you for this opportunity to testify, Mr. Chairman. Again, we will have broad-based recommendations for the committee toward the end of August and we would be happy to work with you at that time.

[The prepared statement follows:]

TESTIMONY OF RAYMOND C. SCHEPPACH, EXECUTIVE DIRECTOR NATIONAL GOVERNORS' ASSOCIATION

Good morning Mr. Chairman and members of the Committee. I am pleased to be here today to present the Governors' views on the need to reform the nation's health-care system.

Under the leadership of our Ghairman, Governor Booth Gardner, the National Governors' Association (NGA) established a 14 Governor Task Force on Health Care to make recommendations for comprehensive reform of our health care system. The Task Force is developing policy that will be considered at our annual meeting this August.

Because our policy is still being developed, I am unable to outline specific policy recommendations. Instead, I shall raise the problems inherent in our health care system and in Medicaid. Then I shall discuss some themes that are emerging in the policy discussions around health care reform.

Problems Inherent in the Health Care System

The United States health-care system is commonly referred to as a patchwork -- and for good reason. Although most Americans have access to health insurance through their place of employment, Medicare, or Medicaid, the limits of each source of coverage leave between 31 and 37 million Americans without access to any health care coverage whatever.

Our system does not ensure that people enter the system at the most appropriate level of care. And countless millions of Americans with preexisting conditions cannot get coverage for the type of care or services they most need. Inadequate access to a range of necessary services, particularly primary and preventive care, bring people into the system on the back end, when they are sicker and where the care required is more acute, and much more expensive.

Further, the costs of our present health care system are out of control. This is having a major impact on small business and United States competition in many manufacturing industries. The inflation rate in health care is growing at twice the rate of general inflation. At the current rate of growth, health care costs are projected to rise from 10.5 percent in 1991 to 17 percent of our gross national product (GNP) by the year 2000.

Problems Inherent in Medicaid

Medicaid, too, is suffering and straining under the weight of rising health care costs, increased demand, and an inability to adequately meet the needs of all people now under its care.

Since its inception in 1965 as a federal-state program to provide health insurance to women and children eligible for Aid to Families with Dependent Children (AFDC), Medicaid has grown larger than any other federal or private health insurance program.

Now serving almost 25 million people, Medicaid has lost a clearly defined purpose. In addition to serving its categorically eligible clients, primarily women and children eligible for AFDC, Medicaid now struggles to provide a broad array of services ranging from prenatal and well-child care through long-term care to four distinct populations:

- Pregnant women and children with income above AFDC levels but below certain percentages of poverty;
- Near-poor elderly individuals and chronically ill children in need of long-term care;
- Mentally retarded and mentally ill persons; and
- Poor elderly who are covered under Medicare.

These expansions have had a profound impact on the Medicaid program. The fastest-growing portion of state budgets, Medicaid spending increased by 18.4 percent in 1990 alone and is expected

to increase more than 25 percent this year. Medicaid spending reached almost $70 billion in fiscal 1990, and is projected to reach $100 billion by 1995.

Although originally created to serve women and children, a major portion of Medicaid resources -- 42.5 percent or $29.5 billion -- is now spent on long-term care services, primarily for persons who are elderly and disabled. Medicaid's ability to effectively accomplish its original mission is now severely hamstrung by these added financial demands.

Medicaid is no longer appropriately oriented toward the provision and delivery of preventive and primary care services. The primary objective of the program, and its ability to serve the very population it was initially created to help, is obscured both in focus and available resources.

Restrictions on services provided in managed care settings or in home or community-based settings also hinder the states' ability to effectively and efficiently serve those who depend on Medicaid.

These requirements, coupled with mounting administrative burdens, runaway health care inflation, and dramatic increases in caseload, all contribute to Medicaid's inability to meet the care needs of those eligible for Medicaid assistance.

The Governors believe that long-term health care reform requires a fundamental restructuring of Medicaid to develop a new public program better equipped to provide access to health care for low-income people without insurance.

Here are some of the questions the Governors are trying to answer in regard to the future of Medicaid:

1. Would it be more appropriate to move long-term care for the elderly out of the Medicaid program? Because Medicaid is an acute care program with an institutional bias, it may not be the best program to provide long-term care service.

2. Would it be more appropriate to establish separate programs for other specified Medicaid populations? As with long-term care for the elderly, establishing separate programs designed to meet the unique financing and service needs of the mentally retarded and mentally ill populations may make more sense.

3. Should Medicare benefits be enhanced to circumvent cost shifting to Medicaid? Maybe Medicare should provide long-term care benefits and protection against catastrophic health care expenses. If the original intent of the Medicare program is to protect the elderly and disabled, it should honor that commitment and assume its financial responsibility.

4. Is it time to break the link between Medicaid and categorical eligibility from welfare and establish a new program of publicly funded health insurance to meet the health care needs of diverse populations? This would simplify the eligibility process and provide flexibility for adapting the Medicaid program to future health system reform.

5. Shouldn't states be given the flexibility with Medicaid to pursue some of the same cost-saving strategies used by the private sector and Medicare? For example, Medicaid is precluded by law from the widespread use of managed care initiatives.

NGA Report/Policy

In August, at the Governors' next annual meeting in Seattle, Washington, the Health Care Task Force will produce a detailed report outlining state options to increase access to health care and to control costs. It also will propose a policy on immediate and long-term reform issues that require federal action such as statewide prototypes to test reform strategies and recommendations on restructuring Medicaid.

The report will identify both incremental and comprehensive strategies to expand access to care and control costs within our current system.

Access to care strategies could include:

- Maximizing access to acute care services under Medicaid;
- Subsidized non-group insurance for both the working and non- working uninsured;
- Small market reforms to make health insurance more affordable and easier to access;
- Programs to meet the health care needs of a specified population, such as children or the developmentally disabled;
- Hospital-based uncompensated care subsidy programs under which provider-based taxes or donations finance care for persons who are medically indigent; and
- Increased use of public hospitals, community health centers, and school-based clinics.

Cost containment strategies could include:

- Wider use of managed care;
- Administrative reforms to decrease health care costs associated with our present system;
- Medical tort reforms to lower the cost of health care;
- State level all-payor systems that negotiate fees to eliminate cost shifting though the health care delivery system; and
- Global budgeting to put a lid on runaway health care inflation.

The Governors believe that cost containment is essential to increase access to health care. They also believe that the state level is the appropriate place to make resource allocation decisions. States are both large enough to provide an adequate market force and small enough to recognize special and different needs.

The report will also outline ways states can reorient their health care systems to emphasize preventive and primary care.

The policy will complement the state action report. It will focus particularly on gubernatorial recommendations for federal action to restructure the health care system, and will make specific recommendations on the future of the Medicaid.

Themes

Several themes have emerged in Governors' discussions of comprehensive policy to restructure the U.S. health care system. In discussing these themes, I am not presenting NGA policy, but rather my own speculation on our overall direction.

1. The Governors must be major participants in any national consensus on health care reform. A significant number of the policy levers to reform in this country reside at the state level.

2. Cost control and access are inextricably linked. The failure to control health care costs in any reform will significantly reduce the possibility of enhancing access.

   The states' interest in cost control ranges from discrete strategies such as increased incentives for managed care, to comprehensive, innovative strategies such as an all-payor system that includes rate negotiation and global budgeting for capital expansion.

3. While access and financing lend themselves to federal policy, it is likely that cost control and program administration of any new policy would have to be done at the state level.

4. Because the current health care market is not competitive, federal and state policy must drive it in one of two directions:

   a) more competitive; or
   b) regulated.

5. Medicaid needs restructuring to enable it to accomplish its original mission. It may make sense for long-term care services for the elderly, now provided under Medicaid, to be separated out of Medicaid and moved to a federal program. Likewise, it may make sense to create a separate program to meet the social service needs of the people with mental, physical, or developmental disabilities.

6. The health care system must be more prevention-oriented.

7. Finally, a new federal-state partnership is essential to move the nation forward in several key areas. For example, these areas could include a new program with a prevention orientation for our nation's children, changes to make insurance available to employees of small businesses, and common strategies to curb escalating costs throughout the system.

To move forward as a nation toward our shared goal of universal access to quality health care for all Americans, there must be federal support for state-wide prototypes to test both incremental and comprehensive strategies for reform. The nation's Governors look forward to working closely with this committee to reach this goal.

Thank you for the opportunity to testify. I will be happy to answer any questions.

Chairman STARK. I have just a couple of observations. Given the experience with Medicare waivers, three of the four States which had them have given them up. So why should we assume that the cost containment policy would be better done at the State level when those who have tried have given up? I will go on and let you respond. I gather from reading your testimony that you would like Medicaid or whatever we replace it with to be a categorically eligible program. That leaves a huge number of poor and near poor without insurance. How do you deal with those? Those are my two concerns.

States all have problems. If they spend a lot more when times are good, who cares? When times are bad, everybody wants to cut back on everything, whether it's health care or not.

But just on those two, why can't we just have a broad social mix, and say everybody's in the box?

Mr. SCHEPPACH. If you look at the other systems, internationally, I'm not sure that any do cost control fully at the Federal level. The Canadian system does it at the provincial level, even in England they allocate it by district. So I think although you can do some——

Chairman STARK. I have no quarrel with that.

Mr. SCHEPPACH. That's the first point. The second point, I think, when you are referring to those individual States, they did it piecemeal at that particular time. I think the feeling is that you have got to get everybody into the box in terms of global budgeting and get a hold on the capital as well. To do it for the operating costs alone is a problem.

And for that reason, I think that they essentially have backed off.

On your second question, on whether Medicaid should be categorical, it depends on how it really fits into the whole system. Are you going to go to universal care where everybody is, in fact covered, or are you going to end up like the Mitchell plan and do a combination of mandates?

I think if you are doing the Mitchell plan where you are doing a number of mandates and then you have a residual sort of public program, I think that——

Chairman STARK. His residual program is Medicaid, if you read that bill.

Mr. SCHEPPACH. They name it something else.

Chairman STARK. But it's Medicaid, it's all the worst features of Medicaid dressed up in new clothes. There is no cost containment. If you believe that this voluntary idea of a bunch of people getting together to cut their fees and rates then you are dealing with winged pigs and boiling seas.

Mr. SCHEPPACH. It's a major problem. I think cost control has got to be done the same time you do the access. I think too many people up here look at only the access issue. If you are going to increase spending considerably without meaningful cost control, you may see an inflation rate of 14 to 15 percent.

Well, I mean there is some evidence that inflation, in fact, may be accelerating.

Chairman STARK. Do you know any other way than a single-payer system, whether done State-by-State or federally to really

contain cost? I mean, all-payer I take as a subsection of single-payer, but is there any other way?

Mr. SCHEPPACH. Well, I think there is a competitive model. It's unclear to me whether it works or not, but I don't think it's been tried. You would have to do a number of significant policy changes. I mean——

Chairman STARK. Given the present provider system, which I don't think politically we will ever change, is there any other way?

Mr. SCHEPPACH. I don't think we know. I think you might want to try a competitive model.

You have got to be serious about the information portion of it. Consumers don't have any information on what prices are, what services are.

Chairman STARK. They don't pay, they don't.

Mr. SCHEPPACH. No, but part of the competitive model would be to, in fact, increase the out-of-pocket costs. It would be getting rid of your tax subsidy of——

Chairman STARK. Then you get to the Stark idea of who do you know that really goes shopping for a proctoscopic examination? You know? Even if I offered you two for the price of one.

Mr. SCHEPPACH. We would have to set that one aside, Mr. Chairman. I'm not defending them all, but I'm saying that you have got the worst of all possible worlds right now. You've got a market that doesn't work, but what we do know is that it's either got to be moved dramatically toward a competitive model or probably the approach that you're talking about, we need to go to an all-payer or a single-payer.

I think where the Governors are, to some extent, is that it may be appropriate to do some serious statewide prototypes on those various approaches so that we get a handle on what works. I think there's some risk of going one way or the other from a Federal/national top-down approach at this particular time.

Chairman STARK. The Stark approach would be to say to your members, we'll sell you Medicare. It will cost $1,000 for an under-65 adult. You can't buy it for that price in the market, see, because we don't have that much overhead.

But we have to have everybody in the State because otherwise we would get terrible adverse selection. So you get everybody in the State, put them under Medicare, then bust at the State level with the supplements. Are there still big gaps?

Mr. SCHEPPACH. You are saying everybody, all low-income or everybody?

Chairman STARK. All Medicaid, all the uninsured, everybody.

Mr. SCHEPPACH. But people who still get it through their work place would continue to get it through their work place?

Chairman STARK. If, in fact, you could do that, and if, in fact, we passed the law that said there would be no medical underwriting. But I'm saying, everybody has it as a base, including through the work place, then the employer deals with supplements. I mean Medicare, when you think about it, is not all that generous. There's a hell of a lot of deductibles and copays in there that——

Mr. SCHEPPACH. The only problem, I think is there is a lot of cost shifting. You know, States are not the only ones that are cost shifting. Medicare is cost shifting also.

Chairman STARK. But this would end, you see, because then everybody in your State would receive Medicare fees.

Mr. SCHEPPACH. But also on the private, employer side, too?

Chairman STARK. I am not suggesting to you that——

Mr. SCHEPPACH. Then I think you would eventually run into problems on a hospital-by-hospital basis as populations shift and technology shifts and so on. Not a lot of nations have taken that approach and had it work effectively.

Chairman STARK. Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

Could the Massachusetts experience and their valiant attempt at universal coverage serve as for what programs States can or cannot provide?

Mr. SCHEPPACH. I think the State of Hawaii has had universal care for probably 15 to 20 years and that's an example that you might look to as opposed to Massachusetts.

I think that if States were in better financial shape right now you'd have a lot of movement on this particular area. That we have enormous interest in States moving forward on the access and on the cost control side right now.

Chairman STARK. Don't you think that in Hawaii, and I think they have an admirable system, but the Hawaii system would not exist without Harry Bridges?

It is a very highly organized State, and the health system is great, but it's not complete. It leaves about 10 percent falling through the cracks.

Mr. SCHEPPACH. Yes, but that's being filled right now though. States are beginning to get real serious about it. The question for you is do you think you have a national consensus on the type of approach that you need or do you need a period where States move forward—I am talking about five to eight States on a comprehensive prototypes, both doing major changes on the access and cost side—to bring back information to you so that you can, in fact, make an informed judgment?

We did that in the welfare reform. We went out and we had 19 to 20 States, Massachusetts happened to be one of them, where we did a lot of experimentation in terms of getting people through job training and getting off welfare rolls. We came back to the Congress with good evaluations and so on and we developed a national program which I think is beginning to work.

We think that may be a sensible strategy here. It could be that either if you do the Mitchell plan or the so-called Canadian model, you could make some significant mistakes at it that would cause some long-term problems. This is a $700 billion industry with significant problems.

Chairman STARK. Well, there's one problem. The States, as is pointed out by our more conservative friends all the time, generally have trouble with deficits. And so in bad times——

Mr. SCHEPPACH. They have a different problem than you do, Mr. Chairman.

Chairman STARK. Yes, in bad times there's no money and so to have a system where you won't have a shortage of funds, you almost have to do it at a Federal level.

Mr. SCHEPPACH. Well, there's a difference between the financing of it, and the administration of it. And we——

Chairman STARK. We pay, you run.

Mr. SCHEPPACH. Well, I'm not saying that. All I'm saying is there is a difference. I mean if you want to run it and finance it, be my guest.

Chairman STARK. I have a hunch that we probably would not finance it, without keeping our hand in.

Mr. SCHEPPACH. You want a little bit of our money?

Chairman STARK. Sure, gas tax, how's that?

Dr. McDermott.

Mr. MCDERMOTT. I'm curious how many of the States you think would be willing to take this on, and give me a sort of an outline of what you think might work? I was a participant in Washington State in putting together the Washington Basic Health Plan and know the difficulties in getting that started. Are you talking about taking something like that and expanding it to the full 600,000 people in the State of Washington, who are not presently covered?

Mr. SCHEPPACH. Yes, I think what we're talking about, and of course, again, this is something that is under discussion for policy with the Governors and I won't know whether they will all adopt it or not, but I think we are looking at a possible two- to three-step process.

First, we have, I think, 15 to 20 States who are interested in moving forward. I think there are several foundations who will probably provide $40 to $50 million over the next couple of years to help design some statewide approaches. If we can get that moving, in terms of the design and the approaches, and if you, the Congress, are willing to provide us some waiver authority on the Medicare and the Medicaid, particularly if we choose the global budgeting approach, and some additional funding to help underwrite the cost of those, I think we can move forward fairly aggressively over the next several years.

But, yes—there are a lot of things on the drawing board that are not what I would call small pilot projects. I agree with many of the members that we are beyond that stage. We have got to move to what I would call prototypes which means comprehensive pay-or-play types of approaches, as was done in Massachusetts, which the State of Washington is considering, the State of Oregon has a different plan, and New York has been planning for a full system—these are all fairly comprehensive initiatives.

Mr. MCDERMOTT. You actually think that Governors would be willing to go at their small employers and say, you either pay or you play? They want to take the heat for that?

Mr. SCHEPPACH. Well, again, you may have to do something like the Mitchell plan in terms of some tax credits and some subsidies in the short run, to set up some State purchasing boards where you can get some economies of scale in purchasing health care from providers, but I think you will find that some of them will be willing to do it.

Mr. MCDERMOTT. When we started the Washington basic health plan, the State house speaker and I were working and he suggested pay-or-play and I said, Joe, why don't you start it over in the

House? He came back 2 days later and said, you know, I think we will just take it out of the treasury.

And I am not sure you are going to find any Governors who are going to want to take the heat for putting in pay-or-play. I think that's one of those things you would like us to do for you, perhaps.

Mr. SCHEPPACH. I'm not sure they want you to do it right now.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. Thank you, very much. We look forward to working with your members and see if we can work our way out of this by the end of the decade.

Mr. SCHEPPACH. Thank you, Mr. Chairman.

Chairman STARK. Our next witness is Dr. Paul Ginsburg, the Executive Director of PhysPRC, otherwise known as the Physician Payment Review Commission.

Paul, welcome back and proceed in any manner that you are comfortable.

STATEMENT OF PAUL B. GINSBURG, PH.D., EXECUTIVE DIRECTOR, PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. GINSBURG. Thank you, Mr. Chairman.

I am Paul B. Ginsburg, and I am pleased to be testifying at this hearing for health insurance for low-income people. I would like to review the Commission's forthcoming study of Medicaid physician payment. The background of this is that OBRA 1989 asked the Commission to study and report on the adequacy of physician fees, physician participation, and beneficiary access in the Medicaid program by July 1 of this year.

The study is complete now. Much of it has appeared in previous annual reports of the Commission—both in the 1990 and 1991 annual reports. The full study will be transmitted on July 1. OBRA 1990 gave the Commission a continuing mandate to advise Congress on policies concerning access to care and the level of Medicaid payments to physicians.

The July report has three main components. One is the finding from a survey of fee levels and participation that was conducted in conjunction with the National Governors' Association. The report also summarizes the research on the relationship between fees and access to care, and it spells out potential options for reform.

The current policy on Medicaid fees is this: States have broad discretion in setting the fees and the only requirement is that the fees be consistent with efficiency, economy, and quality of care and produce enough providers so that services will be available to at least the same extent as they are available to the general population. These rules are much less prescriptive than the Federal rules for hospital payments. As far as payment mechanisms, the States tend to use fee schedules. Some are linked to Medicare payments, but many are not.

Budget problems in States have often precluded updates in these fee schedules. In recent years, however, there have been some selected increases for obstetrical and pediatric services.

Concerning the research on fees and access, it is clear that low fees discourage physician participation in Medicaid and the number of Medicaid patients that a participant treats. There has

been no finding of a relationship between fee levels and the number of services per enrollee in the aggregate. However, fee levels do affect the site of care. In States where fees are low, less care is provided in physician's offices, and more is provided in clinics, emergency rooms, and hospital outpatient departments.

The PPRC/NGA survey was a survey to State Medicaid directors which involved some extensive followup until all the data were consistent. And one of the findings was that almost all the States identified low physician participation as a significant problem in their Medicaid programs. They mentioned particular problems in rural areas and with obstetrics and pediatrics. We found wide variation in fee levels. Some States have fees 50 percent or more above the national average for Medicaid programs. Examples are Alaska, Georgia, Indiana, and Nevada. On the other hand, some States, notably New Jersey and New York, have fee levels about half the national average for Medicaid.

When we compared these fees to Medicare levels, we found the average fee was 64 percent of Medicare levels. Here we also had extensive variation from State to State. We found there were five States that had fee levels that were on average higher than Medicare. Some States had fees that were only a small fraction of Medicare, most notably, West Virginia, at 36 percent of Medicare levels, New Jersey at 32 percent of Medicare; and New York which was the lowest at 26 percent of Medicare.

The Commission feels that access to mainstream care will be elusive as long as Medicaid fees are substantially below Medicare and other payers. Efforts to improve access, however, must consider the financial pressures facing both the State and Federal Governments. Under current financing arrangements, a Federal mandate of substantial increases in fees in Medicaid programs would strain many State budgets, and some of the gain in fees could come at the expense of reduced eligibility and service coverage.

It appears as though some of the best opportunities for substantial change in Medicaid physician payment may be in the context of a more comprehensive health care reform.

Thank you, very much.

[The prepared statement follows:]

TESTIMONY OF PAUL B. GINSBURG, EXECUTIVE DIRECTOR PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman, I appreciate the opportunity to testify today on behalf of the Physician Payment Review Commission concerning Medicaid physician payment. The Commission has just completed a congressionally mandated study of the adequacy of physician fees, physician participation, and beneficiary access to care in state Medicaid programs and will submit its report by July 1. We intend to continue significant work in this area in accordance with the OBRA90 provision broadening our mandate to include consideration of policies concerning access to care and the level of Medicaid payments to physicians.

Our July report reviews research on the relationship between physician fees and access to care, and spells out potential options for reform. I have been asked to focus on current patterns in Medicaid physician payment and will draw heavily on the results of the Commission's survey of Medicaid programs conducted under contract by the National Governors' Association. Although state Medicaid programs spent $3.4 billion on physicians services in 1989 for services rendered to over 15 million beneficiaries, little information has been available on payment methods, physician participation, and fee levels across states. The Commission's survey represents the most recent, consistent and comprehensive source of information on Medicaid physician payment.

The findings of this survey confirm earlier analyses that:

- low rates of physician participation in the Medicaid program are a problem in most states;
- low physician fees are thought to be the most important factor limiting physician participation;
- Medicaid physician fees vary widely across states but geographic differences in the cost of practice explain little of this variation; and
- most Medicaid programs pay physicians substantially less than Medicare.

THE CONTEXT OF MEDICAID PHYSICIAN PAYMENT POLICIES

While the primary purpose of the Commission's survey was to collect information on fees, it also provided an opportunity to learn about other factors that affect Medicaid payments and beneficiary access to care. Understanding how states determine fees, how frequently they update payments, problems with physician participation, and policy initiatives to increase participation provides a context for exploring the relationship between fees and access.

Payment Methodology and Updates

States have broad discretion in determining fee levels and payment methodologies. Federal guidelines require only that payment be consistent with efficiency, economy, and quality of care, and be sufficient to enlist enough providers so that services are available to Medicaid beneficiaries at least to the same extent as available to the general population. By contrast, guidelines affecting hospital payments are much more stringent. Medicaid hospital payments must be adequate to assure reasonable access to services of adequate quality while also taking into account geographic location and reasonable travel time.

Most states use either fee schedules or reasonable charge methods to determine physician payments under fee-for-service arrangements. Fee schedules are becoming the dominant methodology with the number of states using them increasing from 31 in 1986 to 42 in 1989. In most states, fee schedules are based on charge data, with uniform rates applied to physicians of all specialties and in all geographic areas.

Budgetary pressures have necessitated that states delay or be selective in updating physician fees. Only 35 states have increased physician fees within the past two years, and even fewer (21) have increased fees for all physicians' services (Table 1). Under current fiscal conditions, states are likely to continue deferring payment updates. Some, like Michigan, have already cut Medicaid physician fees substantially in response to budget crises.

Of the states that have not increased fees across-the-board, some have increased fees only for maternity and pediatric services. This targeting of fee increases closely follows recent state and federal initiatives to broaden eligibility and service coverage for pregnant women and children.

Physician Participation

Many have argued that low physician fees dissuade physicians from accepting Medicaid patients and therefore present an obstacle to care. Physician participation in Medicaid is therefore often considered a barometer for access to care for Medicaid beneficiaries. Empirical evidence suggests that, in fact, higher Medicaid physician fees increase both the likelihood that a physician will treat any Medicaid patients and the number of patients an individual physician treats. While there does not appear to be a relationship between fee levels and the number of services received by Medicaid beneficiaries, fee levels may affect the site of care. That is, in states with low Medicaid physician fees, Medicaid beneficiaries are more likely to obtain care in emergency rooms or hospital outpatient departments than in physicians' offices.

In the Commission's survey, 43 states identified low physician participation as a problem in their program, and more than half (27) identified problems with both geographic and specialty distribution of participating physicians (Table 2). Many states reported problems with the number of Medicaid participants in rural areas. The lack of obstetricians and pediatricians willing to serve Medicaid patients was also widely noted.

As important as the number of physicians willing to treat Medicaid patients is the extent of participating physicians' Medicaid caseloads. Regrettably, because HCFA defines participating physicians as those who submit at least one Medicaid claim annually, participation statistics may obscure important differences between physicians who treat a few Medicaid patients and those with substantial Medicaid caseloads.

To learn more about the extent of individual physicians' Medicaid caseloads, the Commission's survey asked states to identify the distribution of participating physicians by the amounts billed to Medicaid (Table 3). In states that were able to provide this information, 62 percent of participants, on average, billed Medicaid less than $5,000 in 1989. An average of 75 percent of physicians participating in these Medicaid programs billed less than $10,000. These findings are consistent with earlier research and suggest that Medicaid may be only a marginal source of revenue to most physicians.

While factors other than fee levels may affect physicians' willingness to participate in Medicaid -- such as the amount of administrative hassle involved in filing claims and receiving payment -- Medicaid directors in 30 states ranked low fees as the primary reason for low participation (Table 4). The high cost of malpractice insurance premiums was the second most important reason. The threat of a malpractice suit, however, was judged the least important in participation decisions; 33 states ranked this factor sixth or seventh.

MEDICAID PHYSICIAN FEES

In its survey, the Commission obtained detailed information on fee levels for 23 high-volume services of several types: office visits, hospital visits, diagnostic procedures, surgical

procedures, and maternity services. Previously, comparable data had only been available for three services: brief follow-up office visits, appendectomies and deliveries.

Data from the Commission's survey show wide variations in Medicaid physician fees across states and in the levels of Medicaid fees relative to those paid by Medicare. The data also confirm earlier analyses indicating that Medicaid pays physicians considerably less than Medicare. In addition, the survey data suggest that Medicaid programs pay less than the resource-based Medicare Fee Schedule would have paid, had it been implemented at the time of the Commission's survey.[1]

Variation in Medicaid Payments

The Commission's survey indicates that there are very large differences (from threefold to fifteenfold) between the highest and lowest Medicaid physician fees for all services except deliveries. Medicaid fees for five services--intermediate follow-up office visit, intermediate follow-up hospital visit, routine electrocardiogram (EKG), total hysterectomy, and vaginal delivery--provide a snapshot of this variation across states. Intermediate office visits range from $10 in West Virginia to $45 in Alaska. Intermediate hospital visits range from $6 in New York to $70 in Nebraska. Routine EKGs range from $10 in Florida to $55 in Alaska. Total hysterectomies range from $166 in Kentucky to $1,770 in Alaska. Vaginal delivery ranges from $200 in South Dakota to $901 in Georgia.

To provide a more comprehensive measure of the differences in physician fee levels across states, the Commission developed an index to measure the degree of variation in fees across states (Table 5). On average, Alaska, Georgia, Indiana, and Nevada all have Medicaid fees that are at least 150 percent of the average fee across all states for the bundle of services. New Jersey and New York have fee levels that are about half the average level.

Differences in the costs of practice explain little of the variation in fee levels across states. Deflating fees by a geographic cost of practice index reduces variation by less than 10 percent. The remaining variation in Medicaid physician fees may reflect both differences in the market for physician services and deliberate policy decisions made by states. Among these are trade-offs between payment levels for various services, the number of optional services covered, and breadth of eligibility.

Comparing Medicaid and Medicare Fees

When other payers pay higher rates than Medicaid, physicians are less likely to serve Medicaid patients. The Commission's survey indicates that in some states differences in payment levels among payers are quite large.

Medicaid fees are generally lower than Medicare allowed charges.[2] On average, they are about 64 percent of Medicare allowed charges (Table 6). Medicaid fees as a percentage of Medicare allowed charges are highest in Alaska, Arkansas, Georgia, Indiana, Iowa, Minnesota, and Nebraska. The Medicaid to Medicare fee ratio is lowest in New Jersey, New York, and West Virginia.

The ratio of Medicaid to Medicare physician fee levels, however, varies by both service and state. For example, Medicaid fees for intermediate office visits range from 36 percent of Medicare allowed charges in New York to 129 percent in Tennessee. For EKGs, they

---

[1] The Medicare Fee Schedule used in these analyses does not include the 16 percent reduction in the conversion factor recently proposed by the Health Care Financing Administration.

[2] Ideally, the comparison should made be between actual Medicaid payments and Medicare allowed charges. Since Medicaid fee schedule amounts are maximum payments, the comparison here may understate the ratio of Medicaid payments to Medicare charges.

range from 29 percent in Florida to 156 percent in Indiana. For total hysterectomies, they range from 18 percent in New York to 164 percent in Georgia.

The ratio of Medicaid to Medicare fees will change somewhat with implementation of the Medicare Fee Schedule. Overall, Medicaid fees would have been 62 percent of Medicare Fee Schedule payments had the fee schedule been implemented in 1989 (Table 6).[3]

Medicaid programs also pay less than private payers. Although the data to calculate precise ratios are not available, the difference between amounts paid by private payers and Medicaid programs are assumed in most cases to be larger than the differences between Medicaid and Medicare. In 1989, Medicare allowed charges averaged about 78 percent of Blue Cross-Blue Shield allowed charges.

CONCLUSION

Low Medicaid physician fees, problems with physician participation and beneficiary access to care have prompted debate on the merits of raising Medicaid fees to Medicare levels. Although the relationship between physician fees and beneficiary access is not clear-cut, it is the Commission's view that access to mainstream medical care will remain elusive for Medicaid beneficiaries as long as fee levels for physicians' services are substantially below those paid by Medicare and other payers.

Policy efforts to improve access to care, however, must also consider the financial pressures facing state government. For programs already straining under the weight of increasing expenditures, improvements in physician payment may only be gained at the expense of tightened eligibility and constraints on service coverage. It may be prudent therefore to consider reforms in Medicaid physician payment in the context of more comprehensive health care reform.

[3] This ratio differs from the ratio of Medicaid fees to Medicare allowed charges because evaluation and management services, which will receive increased payments under the Medicare Fee Schedule, account for a larger proportion of services in Medicaid programs than in Medicare.

Table 1. Date of Last Update in Medicaid Physician Fees by Category of Service

State	All Fees	Primary Care	Maternity Services	Pediatric Services
AL	Oct-81	Oct-81	Oct-89	Oct-89
AK	Apr-85	Apr-85	Apr-85	Apr-85
AZ	Oct-88	Oct-88	Oct-88	Oct-88
AR	May-86	May-86	May-86	May-86
CA	Aug-85	Aug-85	Nov-89	May-88
CO	Jul-89	Jul-89	Jul-89	Jul-89
CT	Jul-89	Jul-89	Jul-89	Jul-89
DE	1985	1985	Jul-88	1985
DC	1985	1985	Apr-90	1985
FL	Jul-78	Oct-87	Oct-87	Oct-87
GA	Jan-89	Jan-89	Jan-89	Jan-89
HI	Jul-88	Jul-88	Jul-88	Jul-88
ID	Jul-89	Jul-89	Apr-90	Jul-89
IL	Sep-89	Sep-89	Sep-89	Sep-89
IN	N/A	N/A	N/A	N/A
IA	Jul-89	Jul-89	Jul-89	Jul-89
KS	Jul-78	Jul-85	Jul-87	Jul-78
KY	Aug-81	Aug-81	Nov-87	Aug-81
LA	Feb-87	Apr-89	Apr-89	Apr-89
ME	N/A	Jul-88	Jul-88	Jul-88
MD	N/A	Jan-89	Jul-88	Jan-89
MA	Sep-89	Sep-89	Sep-89	Sep-89
MI	Feb-89	Feb-89	Feb-89	Feb-89
MN	Nov-85	Nov-85	Nov-85	Nov-85
MS	Jul-83	Jul-89	Oct-87	Jun-88
MO	Pre 79	Dec-82	Jul-87	Pre 79
MT	Jul-89	Jul-89	Apr-90	Jul-89
NE	Oct-85	Oct-85	Oct-85	Oct-85
NV	N/A	N/A	Apr-88	N/A
NH	N/A	Aug-88	Jul-89	Aug-88
NJ	N/A	May-89	May-89	May-89
NM	Oct-87	Oct-87	Oct-87	Oct-87
NY	Apr-74	Jan-85	Jan-88	Jan-85
NC	Jan-90	Jan-90	Oct-89	Jan-90
ND	Jul-80	Jul-80	Jul-80	Jul-80
OH	Apr-89	Apr-89	Apr-89	Apr-89
OK	Apr-86	Apr-86	Apr-86	Apr-86
OR	Jul-89	Jul-89	Jul-89	Jul-89
PA	Jul-85	Apr-88	Apr-90	Apr-85
RI	Apr-87	Apr-87	Apr-87	Apr-87
SC	Jul-89	Jul-89	Jul-89	Jul-89
SD	Jul-89	Jul-89	Jul-89	Jul-89
TN	Oct-86	May-87	May-87	May-87
TX	Mar-89	Mar-89	Mar-89	Mar-89
UT	Mar-87	Aug-87	Mar-88	Mar-87
VT	Dec-88	Dec-88	Jul-89	Jul-89
VA	Jan-90	Jan-90	Jan-90	Jan-90
WA	Sep-88	Jan-90	Aug-89	Jan-90
WV	Nov-81	Nov-81	Jul-87	Nov-81
WI	Jul-89	Jul-89	Jul-89	Jul-89
WY	N/A	N/A	N/A	N/A

Source: National Governors' Association and Physician Payment Review Commission, 1990.

N/A = Not Available.

Table 2. Problems with Physician Participation

State	Geographic Areas With Low Physician Participation	Specialties With Low Physician Participation
AL		Ob/Gyn and Pediatrics
AZ	Rural Areas	
AR	Rural Areas	Ob/Gyn
CA	Rural Areas	Ob/Gyn
CO	Rural Areas	Ob/Gyn and Pediatrics
CT	North and South Central Regions	General Practice and Pediatrics
DE	Rural Areas	Ob/Gyn and Pediatrics
DC	Southeast Section	Ob/Gyn and Dentistry
FL	Rural Areas	Allergy, Gerontology, Pathology, Child Psychiatry and Rheumatology
GA		Ob/Gyn
HI	Rural Areas	Ob/Gyn and Orthopedics
ID		Ob/Gyn
IL	Rural and Southern Regions	Ob/Gyn
IN	Rural Areas	Ob/Gyn
IA		Ob/Gyn
KS		Ob/Gyn
KY	Rural Areas	Ob/Gyn and Pediatrics
LA		Ob/Gyn and Pediatrics
ME	Urban Areas	Ob/Gyn and Pediatrics
MD	Rural and Affluent Areas	Psychiatry
MA	Areas with Lowest Per Capita Income	General and Family Practice
MI	Rural Areas	Ob/Gyn, Neurosurgery and Orthopedic Surgery
MN	Rural Areas	
MS	Coastal Areas	All Specialties
MO	Southeast and Northwest Areas	Ob/Gyn
MT	Rural Areas	Ob/Gyn and Family Practice
NE	Rural and Urban Areas	Ob/Gyn and Primary Care
NV	Rural Areas	Ob/Gyn, Pediatrics, Dentistry
NH		Dentistry and Podiatry
NJ	Rural and Inner City Areas	Ob/Gyn, Orthopedic Surgery, Pediatrics
NY		Ob/Gyn and Pediatrics
NC	Rural Areas	
OR	Rural Areas	Ob/Gyn
PA	Rural Areas	Ob/Gyn
RI		Ob/Gyn
SC	Rural Areas	
TX	Rural Areas	Ob/Gyn, Pediatrics and Family Practice
UT	Orem and Provo, Rural Areas	
VT		Ob/Gyn
VA	Rural Areas	Ob/Gyn
WA	Rural and Urban Areas	Ob/Gyn and Pediatrics
WV		Specialists
WI	Rural Areas	Ob/Gyn

Source: National Governors' Association and Physician Payment Review Commission, 1990.

Note: Ohio noted problems with low physician participation but did not indicate particular geographic areas or specialties.

Table 3. Distribution of Participating Physicians by Annual Medicaid Billings, 1989

State	$1-$1,000	$1,001-$5,000	$5,001-$10,000	$10,001-$25,000	$25,000-$50,000	$50,001-$75,000	Over $75,000
	(Percent of Participating Physicians)						
AK	21	17	9	17	18	10	9
AR	33	15	19	19	8	3	3
CA	21	21	12	16	12	5	12
CO	29	39	16	11	3	1	1
DE	29	34	17	14	4	1	1
GA	24	22	14	20	11	4	6
IL	38	26	12	14	6	2	2
KS	48	26	10	10	4	1	0
KY	35	22	12	17	8	3	4
LA	25	23	12	22	8	3	5
ME	29	25	15	14	7	2	0
MD	41	25	13	8	12	0	0
MI	29	27	16	18	7	2	2
MS	59	31	7	3	0	0	0
MO	43	29	12	10	4	1	1
NE	38	21	12	14	8	3	2
NJ	46	31	10	7	2	1	1
NY	61	21	7	6	3	0	2
NC	30	30	14	16	6	2	2
ND	43	23	11	12	4	3	3
RI	33	43	15	6	2	0	0
TX	29	30	15	15	6	2	3
WA	32	24	14	17	7	3	5

Source: National Governors' Association and Physician Payment Review Commission, 1990.

Note: Totals may not add to 100 percent due to rounding. New York data reflects 10/1/87 - 9/30/88.

Percentages reflect only those physicians participating in Medicaid.

Table 4. Ranking of Reasons for Low Physician Participation

Reason	Most Important (Rank 1-2)	Moderately Important (Rank 3-5)	Least Important (Rank 6-7)
	(Number of States)		
Malpractice premiums	20	23	4
Patient compliance	10	27	10
Low fees	38	9	1
Payment delays	6	29	11
Clients sue frequently	2	10	33
Complex billing procedures	14	24	9
Disruptive clients	5	18	23

Source: National Governors' Association and Physician Payment Review Commission, 1990.

Note: States were asked to rank reasons from 1 to 7 with 1 being most important and 7 being least important. Not all states included all seven reasons in their rankings. Totals add to more than 51 for each column because of grouped rankings.

Table 5. Index of Relative Medicaid Fees by State

State	Index
Alabama	1.07
Alaska	2.33
Arkansas	1.23
California	1.05
Colorado	.78
Connecticut	1.01
Delaware	.88
District of Columbia	.97
Florida	1.35
Georgia	1.64
Hawaii	1.43
Idaho	.89
Illinois	.82
Indiana	1.55
Iowa	1.21
Kansas	.86
Kentucky	.62
Louisiana	.88
Maine	.67
Maryland	.83
Massachusetts	1.30
Michigan	.85
Minnesota	1.19
Mississippi	.68
Missouri	.61
Montana	.98
Nebraska	1.20
Nevada	1.62
New Hampshire	.69
New Jersey	.50
New Mexico	1.16
New York	.53
North Carolina	1.07
North Dakota	1.01
Ohio	.79
Oklahoma	1.18
Oregon	1.01
Pennsylvania	.77
Rhode Island	.68
South Carolina	.92
South Dakota	.87
Tennessee	1.05
Texas	1.20
Utah	.99
Vermont	.78
Virginia	.81
Washington	.86
West Virginia	.61
Wisconsin	1.02

Source: National Governors' Association and Physician Payment Review Commission, 1990; Health Care Financing Administration, Medicaid Statistical Information System, 1989.

Note: The index measures each state's Medicaid fee level relative to the average for all states. For example, Alabama's Medicaid fees are about 107 percent of average Medicaid fees for all states.

Table 6. Indexes of Medicaid Fees Relative to Medicare Allowed Charges and Fee Schedule Fees by State

State	Index of Allowed Charges	Index of Fee Schedule Fees
Alabama	.80	.73
Alaska	1.07	1.22
Arkansas	1.04	1.05
California	.62	.68
Colorado	.62	.57
Connecticut	.64	.62
Delaware	.71	.61
District of Columbia	.57	.58
Florida	.73	.78
Georgia	1.14	1.07
Hawaii	.78	.90
Idaho	.82	.74
Illinois	.56	.51
Indiana	1.18	1.05
Iowa	1.00	.89
Kansas	.69	.66
Kentucky	.51	.49
Louisiana	.64	.58
Maine	.59	.52
Maryland	.50	.49
Massachusetts	.89	.86
Michigan	.64	.55
Minnesota	1.02	.88
Mississippi	.63	.48
Missouri	.52	.46
Montana	.81	.77
Nebraska	1.03	.95
Nevada	.96	1.11
New Hampshire	.61	.52
New Jersey	.34	.32
New Mexico	.77	.78
New York	.28	.26
North Carolina	.88	.81
North Dakota	.83	.69
Ohio	.63	.60
Oklahoma	.86	.83
Oregon	.75	.74
Pennsylvania	.54	.49
Rhode Island	.48	.48
South Carolina	.82	.70
South Dakota	.77	.71
Tennessee	.88	.82
Texas	.82	.81
Utah	.83	.74
Vermont	.72	.69
Virginia	.74	.65
Washington	.66	.64
West Virginia	.40	.36
Wisconsin	.81	.74

Source: National Governors' Association and Physician Payment Review Commission, 1990. Health Care Financing Administration, BMAD, 1988, and Medicaid Statistical Information System, 1989.

Note: Each index measures Medicaid fees relative to Medicare payments. For example, Alabama's Medicaid fees are, on average, 80 percent of Medicare allowed charges in the state.

Medicare Fee Schedule fees based on budget neutral conversion factor without behavioral offset.

Table 7. Index of Medicaid Fees Relative to Medicare Fee Schedule Fees by State

State	Index
Alabama	.73
Alaska	1.22
Arkansas	1.05
California	.68
Colorado	.57
Connecticut	.62
Delaware	.61
District of Columbia	.58
Florida	.78
Georgia	1.07
Hawaii	.90
Idaho	.74
Illinois	.51
Indiana	1.05
Iowa	.89
Kansas	.66
Kentucky	.49
Louisiana	.58
Maine	.52
Maryland	.49
Massachusetts	.86
Michigan	.55
Minnesota	.88
Mississippi	.48
Missouri	.46
Montana	.77
Nebraska	.95
Nevada	1.11
New Hampshire	.52
New Jersey	.32
New Mexico	.78
New York	.26
North Carolina	.81
North Dakota	.69
Ohio	.60
Oklahoma	.83
Oregon	.74
Pennsylvania	.49
Rhode Island	.48
South Carolina	.70
South Dakota	.71
Tennessee	.82
Texas	.81
Utah	.74
Vermont	.69
Virginia	.65
Washington	.64
West Virginia	.36
Wisconsin	.74

Source: National Governors' Association and Physician Payment Review Commission, 1990. Health Care Financing Administration, BMAD, 1988, and Medicaid Statistical Information System, 1989.

Note: The index measures Medicaid fees relative to estimated 1989 Medicare Fee Schedule fees. For example, Alabama's Medicaid fees are, on average, 73 percent of estimated 1989 fee schedule fees.

Mr. COYNE [presiding]. Thank you, Dr. Ginsburg.

In an attempt to get physicians to be more responsive to taking Medicaid patients, would it make any sense to provide for a tax credit or a tax deduction? Would that encourage physicians?

Mr. GINSBURG. You mean some tax credit to physicians?

Mr. COYNE. Yes.

Mr. GINSBURG. I think it would probably be a lot more efficient, if we wanted to pay physicians more, to pay them higher fees rather than use the various tax credit or deduction mechanisms. And I guess if the Federal Government wanted higher fees to go to physicians, it could either mandate some floor on States, that fees can't be lower than a certain amount or it could perhaps provide some direct supplements. But I think that would be much more straightforward than going the tax credit route.

Mr. COYNE. If Medicaid physician reimbursement were increased could Medicaid beneficiaries be induced to shift from hospital emergency rooms and outpatient clinics to private physicians?

Mr. GINSBURG. I think this will definitely happen because the research gives fairly strong results that when fee levels are higher, more care is delivered in physicians' offices. The problem is that this won't happen overnight. Physician location decisions have been influenced by the fact that if there is a predominantly Medicaid population in an area the fees will be low. So, initially, Medicaid beneficiaries wouldn't find more physicians located in their areas in some States. But over time, I'm sure more private physicians would accept Medicaid, and become more accessible to Medicaid beneficiaries, and you would have this change.

Mr. COYNE. What would be the overall cost of increasing Medicaid fees to the Medicare level?

Mr. GINSBURG. Actually we have a number in our report. We estimate $2.3 billion to have what would basically be a floor at Medicare levels.

Mr. COYNE. Would it make any sense to increase Medicaid fees selectively? Perhaps tying increases to case management responsibilities?

Mr. GINSBURG. Yes, there are a number of ways that we might get a lot more bang for the buck as far as spending more money on Medicaid to increase access by doing some selective fee increases as compared to across-the-board fee increases. And I think one very good idea is to perhaps tie fee increases to participation in a case management system. Some other selective methods could be providing fee increases for obstetrics and pediatrics where there seem to be the most serious access problems. And there are also alternatives outside of the fee-for-service system, such as increasing the capacity of clinics and hospital outpatient departments to provide comprehensive care for Medicaid beneficiaries.

Mr. COYNE. Thank you.

Chairman STARK [presiding]. Paul, thank you, very much. As usual, we appreciate your help and we appreciate your testimony.

Mr. GINSBURG. Thank you.

Chairman STARK. Next we will hear from Jerold Aronson, M.D., from the American Academy of Pediatrics, and Kenneth Robbins, who is the president of the Illinois Hospital Association.

Dr. Aronson, do you want to lead off?

STATEMENT OF JEROLD ARONSON, M.D., NARBERTH, PA., ON BEHALF OF AMERICAN ACADEMY OF PEDIATRICS

Dr. ARONSON. Thank you, Mr. Chairman.

Congressman Stark, Mr. Coyne, and members of the Health Subcommittee of the House Ways and Means Committee, my name is Dr. Jerold Aronson. I am a Medicaid provider including the EPSDT program and I am here today representing the American Academy of Pediatrics, an organization of 41,000 pediatricians dedicated to the promotion of better health for children and adolescents.

My remarks today will address the concerns the academy has regarding access problems of children eligible for coverage under the Medicaid program. Since the 1970s the American Academy has been deeply involved in Medicaid and indigent care issues. This is due, in part, to the fact that there are 12 million children medically indigent; they constitute 15 percent of the U.S. child population, and 50 percent of Medicaid population. These numbers are expected to grow as mandated Federal eligibility expansions are phased in.

After years of advocacy at the Federal and State level to strengthen the Medicaid program by producing a steady stream of research and policy papers, the academy has concluded that Medicaid should not be part of the permanent landscape of health care reform. The principal reason for the academy view that Medicaid should be replaced is that the program cannot escape its inherent second-class status within the health care system. It cannot avoid the welfare stigma perceived by beneficiaries, administrators, physicians or the taxpayers.

When Medicaid was enacted in 1965, it was the intent of Congress to create a program to provide access to mainstream medical care to the poor, by allowing States discretion within Federal guidelines to structure the program's eligibility benefits, provider reimbursement, and administration. But for many reasons, the program has never lived up to its legislative intent.

States are continually facing budget constraints requiring tradeoffs among eligibility benefits and provider reimbursement. Recent congressional mandates expanding eligibility for pregnant women and children represent compassionate public policy. And, yet, they have not been well received by the States. Given the fiscal burdens of the States, as voiced by the National Governors' Association, a lack of additional Federal funds, no new taxes or State revenues to assist the poor, States have little choice but to limit benefits and to further constrain provider reimbursement.

This results in a multiple number of State Medicaid variations, including "robbing Peter to pay Paul." But I am here today to talk about children's needs and specifically how access is affected by the Medicaid program.

A grave concern of the academy is that reduced access to care for Medicaid-eligible children exists for many reasons, including reimbursement and administrative burdens.

The academy has documented a steady decline in pediatrician participation in Medicaid which coincides with a decrease in Medicaid physician reimbursement. In three surveys by the academy—1978, 1983, 1989—the academy has found that nationally the per-

centage of pediatricians who refused to take any Medicaid patients has increased from 15 to 23 percent. The portion of pediatricians who restrict access to their practice by Medicaid beneficiaries has increased from 26 to 39 percent. In 1978, approximately 3 out of 5 pediatricians had practices open to all Medicaid beneficiaries. By 1989, that proportion had dropped to 2 in 5.

In this month's issue of the academy's journal, Pediatrics, there is an analysis of Medicaid fees for pediatric care. The report concludes that there are enormous variations among States in reimbursement for pediatric care, with reimbursement for some services varying by a factor of 9. Nowhere does Medicaid reimburse pediatricians at the market rate.

Mr. Chairman, overhead costs for pediatricians are approximately 54 percent of revenues. On a national basis we have heard that Medicaid's average reimbursement for a new patient visit is 65 to 70 percent of market rate for a sick visit, for an established patient it is 57 percent of market. From a prior study we know that a well-baby visit fee for child health supervision is 53 percent of market rate. Thus, the best a pediatrician can do is hope to break even on Medicaid patients. In many States, the pediatrician knows that every Medicaid visit represents donated time, at best, and often financial loss.

In previous congressional testimony, in correspondence with HCFA and State Medicaid departments, through conference presentations, through journal articles, the academy has reported that independent of fees, pediatricians are withdrawing from the program due to the administrative burdens placed on them. In spite of these reports, between 1978 and 1989, the length of time to fill out a Medicaid claim form increased, payment of Medicaid claims has slowed and the proportion of Medicaid claims returned for additional information has doubled from 1 in 8, to 1 in 4.

Mr. Chairman, "low pay, slow pay, no pay" is the view that pediatricians have of the Medicaid program. Recognizing that without obstetricians and pediatricians the Medicaid expansions of the late 1980s would be of limited value, Congress enacted OBRA 1989 which required States to document new efforts to recruit and retain appropriate numbers of pediatricians and obstetricians to treat Medicaid beneficiaries.

States were required to show that they were either paying 90 percent of market rates or at least half the providers were full Medicaid participants. Full participation was explicitly defined as accepting all Medicaid patients who presented themselves for care. Unfortunately a third option was put in, perhaps the loophole option, which enabled States to assemble other relevant data to demonstrate compliance. There were few specifics given to the States about how this should be done. Indeed, my own State of Pennsylvania was judged in compliance with this new law in 1990 based upon 50 percent participation rate. However, Pennsylvania defined Medicaid providers as fully participating if they have billed just one service during the year. This was in, as far as we could determine, direct violation of the law. The plan was approved, however. Regulations had been promised by HCFA, as you know, but now the second year of State reporting has passed and it is our understanding that there will still be further delays.

Mr. Chairman, administration commitment to implement OBRA 1989 is clearly lacking and this is resulting in poor access for poor children for medical care.

AAP has testified at PPRC and elsewhere that we believe that children would have increased access to private office-based care if an enhanced reimbursement schedule was adopted by Medicaid. We see Medicaid reform as an interim step until more comprehensive health care system reform provides the universal access to health care that all Americans, particularly children, who are innocent victims of the current hodge-podge financing system actually need.

The AAP is developing a proposal soon to be introduced, which addresses access for children and women first, which recommends the creation of a one-class system of care financed by employers, current State and Federal Medicaid expenditures, and small Federal subsidy for low-wage workers and families.

The AAP does not favor a single-payer system. We prefer a market-oriented approach with private insurers competing under Federal and State regulation to provide obstetrics and pediatric care, promoting freedom of choice, and assuring a one-class system of patient care with uniform benefits and fair compensation. Until legislation of this type is enacted we will continue to encourage and fight for incremental expansion of Medicaid and private insurance to cover as many children as possible.

We appreciate the opportunity to share these remarks and I would be pleased to answer any questions you might have.

Thank you.

[The prepared statement follows:]

TESTIMONY OF JEROLD ARONSON, M.D.
AMERICAN ACADEMY OF PEDIATRICS

Congressman Stark and members of the Health Subcommittee of the House Ways and Means Committee, my name is Jerold Aronson, M.D. I am here today representing the American Academy of Pediatrics (AAP), an organization of 41,000 pediatricians dedicated to the promotion of better health for children and adolescents. My remarks today will address concerns that the AAP has regarding the access problems of children eligible for coverage under the Medicaid program.

Since the 1970s, the AAP has been deeply involved in Medicaid and indigent care issues. This is due in part to the fact that 12 million children are beneficiaries. They constitute 15% of the U.S. child population and 50% of the Medicaid population. These numbers will grow as mandated federal eligibility expansions are phased in.

After years of advocacy at the federal and state level to strengthen the program by producing a steady stream of research and policy papers, the AAP has concluded that Medicaid should not be a part of the permanent landscape of health care reform. The principal reason for the AAP view that Medicaid should be replaced is that the program cannot escape its inherent second class status within the health care system. It cannot avoid the welfare stigma perceived by its beneficiaries, administrators, physicians or the taxpayers.

When the Medicaid legislation was enacted in 1965 it was the intent of Congress to create a program to provide access to mainstream medical care for the poor by allowing states discretion, within federal guidelines, to structure the program's eligibility, benefits, provider reimbursement, and administration. For many reasons, the program has never lived up to its legislative intent.

States are continually facing budget constraints requiring trade-offs among eligibility, benefits, and provider reimbursement. Recent Congressional mandates expanding eligibility for pregnant women and children represent compassionate public policy, yet have not been well-received by the states. Given the fiscal burdens of the states as voiced by the National Governor's Association, lack of additional federal funds and no new taxes or state revenues to assist the poor, states have little choice but to limit benefits and further constrain reimbursement. This results in a multiple number of state variations, including "robbing Peter to pay Paul."

But, I am here today to talk about children's needs, specifically how they are affected by the Medicaid Program. Of grave concern to the Academy is the reduced access to care for Medicaid-eligible children that exists for a variety of reasons. These include reimbursement and administrative burdens.

The Academy has documented a steady decline in pediatrician participation in Medicaid which coincides with the decrease in Medicaid physician reimbursement. In three surveys conducted by the AAP in 1978, 1983 and 1989, (See Yudkowsky BK, Cartland, JDC, Flint SS. Pediatrician Participation in Medicaid: 1978 to 1989, Pediatrics, April 1990, pp 567-577), we have found that nationally, the percentage of pediatricians who refuse to take any Medicaid patients has increased from 15% to 23%. The portion of pediatricians who restrict access to their practice by Medicaid beneficiaries has increased from 26% to 39%. Thus, in 1978 approximately 3 in 5 pediatricians had practices open to all Medicaid beneficiaries, but by 1989 that proportion dropped to 2 and 5.

In this month's issue of the AAP's journal, Pediatrics, there is an analysis of Medicaid fees for pediatric care. (McManus M, Flint S, and Kelly R. The Adequacy of Physician Reimbursement for Pediatric Care Under Medicaid. Pediatrics, June 1991, pp 909-920.) The report concludes that there are enormous variations among states in reimbursement for pediatric care (with reimbursement for some services varying by a factor of nine), but nowhere does Medicaid reimburse physicians at the market rate.

Overhead costs for pediatricians are approximately 54% of revenues. Nationally, Medicaid's average reimbursement for a new patient visit is 70% of the market rate; for a "sick visit" for an established patient it is 57% of market; and (from a previous study) we know a "well baby" (child health supervision) visit is 53% of the market rate. Thus, the best a pediatrician can do is hope to break even on Medicaid patients, and in many states he/she knows that every Medicaid visit represents donated time at best and often times financial loss.

In previous Congressional testimony, correspondence with HCFA and state Medicaid departments, through conference presentations and journal articles, the AAP has reported that independent of fees, pediatricians are withdrawing from the program due to administrative burdens placed on them. In spite of these reports, between 1978 and 1989, the length of time to fill out a claim increased, payment of claims has slowed, and the proportion of claims returned for additional information has doubled from 1 in 8 to 1 in 4.

Recognizing that without obstetricians and pediatricians, the Medicaid expansions of the late 1980s are of limited value, the Congress enacted (as part of OBRA '89) state reporting requirements to document efforts to recruit and retain appropriate numbers of pediatricians and obstetricians to treat Medicaid beneficiaries. States are required to show that they are either paying 90% of market rates or at least half of all pediatric providers are "full Medicaid participants". Full participation was explicitly defined in the guidance material as "accepting all Medicaid patients who present themselves for care". One other option permits states to assemble other relevant data to demonstrate compliance, but few specifics suggest how this should be done.

My own state of Pennsylvania was judged in compliance with the new law based on the 50% participation option in 1990. However, Pennsylvania reporting included Medicaid providers who had billed for just one service during the year as full participants. This was in direct violation of the specific definitions provided to the states. Despite this, the plan was approved by the regional office. Regulations have been promised by HCFA but now the second year of state reporting has passed and it is our understanding that there will be further delays. Administration commitment to implement this legislation is clearly lacking, resulting in fewer poor children obtaining medically necessary and appropriate care.

The American Academy of Pediatrics has testified at the Physician Payment Review Commission and elsewhere that we believe children would have increased access to private, office-based pediatric care if an enhanced reimbursement schedule was adopted by Medicaid.

We see Medicaid reform as an interim step until more comprehensive health care system reform provides the universal access to care that all Americans need, particularly children who are innocent victims of the current

hodgepodge financing system. We have developed a proposal addressing access for children and pregnant women first, soon to be introduced in Congress, which recommends the creation of a one-class system of care financed by employers, current state and federal Medicaid expenditures, and a small federal subsidy for low-wage workers and families.

The American Academy of Pediatrics does not favor a single-payer system. We prefer a market-oriented approach with private insurers competing under federal and state regulation to provide obstetric and pediatric care which promotes freedom of choice and assures a one-class system of patient care with uniform benefits and fair compensation. Until legislation of this type is enacted, we will continue to support expansion of Medicaid and private insurance plans to cover as many children as possible.

Thank you for the opportunity to share these remarks. I would be pleased to answer any questions you may have.

Chairman STARK. OK, remind me to come back to that single-payer statement after we hear from Mr. Robbins.

Mr. Robbins.

STATEMENT OF KENNETH C. ROBBINS, PRESIDENT, ILLINOIS HOSPITAL ASSOCIATION

Mr. ROBBINS. Thank you, Mr. Chairman, Mr. Coyne.

It's hardly a novel observation to suggest that our health care system is lurching toward a meltdown unless something dramatic happens and happens soon. There are lots of calls for reforms, some mesh with each other and some do not. From the heartland I can tell you that it sounds more like a cacophony of calls for reform than a chorus of calls.

And so I would urge the administration and the Congress to elevate this issue to a higher position on its agenda than it has enjoyed in the past. We have heard much discussion about the Medicaid program and if you don't mind, I would like to focus on the Illinois experience for the balance of my remarks.

We have been exposed to a decade of indifference to the Medicaid program in Illinois. Our former Governor used to like to paint the picture that Medicaid was the monster that was eating the State's budget, but the facts belie that assertion. In 1980, Medicaid represented about 18 percent of the State's budget. In 1990, it represented about 17 percent of the State's budget. To put it differently, in inflation adjusted dollars, in 1980, the State was spending $1.4 billion on the hospital portion of the Medicaid program, and in 1990 was spending $885 million on the hospital portion of the Medicaid program.

In a study that is to be released by the American Hospital Association this Saturday, the study will demonstrate that Illinois pays the lowest percentage of hospital costs of any State program in the country.

Chairman STARK. How does California stack up?

Mr. ROBBINS. California is close to Illinois and it is not an accident, by the way——

Chairman STARK. I'm sure it's not.

Mr. ROBBINS. Both of those States have been operating their Medicaid programs subject to a Federal waiver about which I would like to comment more later. We are faced in Illinois with a program that pays doctors about 40 percent of their costs, hospitals less than 70 percent of their costs, and in total $350 million a year less than we actually spend—not charges now but costs—spend to treat Medicaid patients, and we, too, have a slow-pay problem.

The average Illinois hospital bill is paid about 110 days after the bill is presented to the public aid department. In effect, we are being asked to serve as bankers for the State, and we were not designed to be financial institutions, but they treat us as if we were.

Yet, they are also able, at the same time, to meet their biweekly payrolls for their employees, and to fund sports stadiums and convention halls, to open foreign trade offices in Europe and Japan.

I think it is a question of priorities and values and I think they have fallen off the track.

We are now faced, in spite of that history, with a new budget proposal—which I left Springfield at some risk to come here to have this discussion, while that debate is ongoing—which proposes to cut 19 percent more from that already inadequate budget.

One of the principal concerns that we have with the future is the approach that the State is proposing to take. It is interesting and it ought to be of interest to Congress. The Governor has said that the way to avoid that 19 proposed budget cut in hospital spending is to tax hospitals to generate that lost State revenue to keep the Federal match money that we have had coming into the State, coming in.

Now, I frankly might be enamored of that notion if it were to raise the level of payment to providers and put some of our money on the table for that purpose, but quite frankly, they are simply substituting the bait in the trap.

It becomes our bait, not theirs, but you continue to spend.

Chairman STARK. Just think if we taxed Boeing and McDonnell Douglas to pay for the defense budget.

Mr. ROBBINS. It would be the same idea.

Chairman STARK. That's a good idea, I like that.

Mr. ROBBINS. Perhaps we have new public policy in the making here, Mr. Chairman.

In addition, of course, we have a tremendous uncompensated care problem in our State, as in other States, $450 million a year in costs to the hospitals for providing that care. We sought to impose a pay-or-play employer mandated benefit piece of legislation about 3 years ago. I think I did more for the membership of the State Chamber of Commerce in that one act than I might have done for my own hospitals.

They clearly rose up in arms against it and the cost shift in total in Illinois is $1.2 billion a year, and the average commercially insured patient's hospital bill has increased by 35 percent as a result of that cost shift and the business community is also up in arms over it and I can understand why they would be. What I can't understand is why they find it so hard to always be against everything and for nothing.

In short, we have become bankers to the State, and we have become sick tax collectors for State and Federal Governments, we have become transfer agents whose job appears to be to take money from those who have it to give it to those who don't.

I think it's an inappropriate role for medical providers to be asked to pay. If that sort of transfer policy is valid policy, it ought to be the result of explicit legislative debate and decisionmaking, not the sort of backdoor budget policy results that we see when you don't have a health care policy.

I would be pleased to answer any questions you might have, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF KENNETH C. ROBBINS
ILLINOIS HOSPITAL ASSOCIATION

Good morning, Mr. Chairman, and thank you for inviting me to speak at this subcommittee meeting today on a subject of increasingly critical importance to the well-being of all Americans.

The American healthcare delivery system is lurching toward meltdown. There are over 33 million Americans who are not covered by any form of health insurance today -- they have no private insurance, no government sponsorship, and no money.

At the same time government sponsors -- such as Medicare and Medicaid -- have failed to adequately fund their programs, and private insurers are paying cost-shift-swollen rates which they immediately pass through to employers who are increasingly unwillingly to pick up the tab.

As a result there is a rapid increase in the decibel level of the debate and the number of people calling for national reform of the healthcare system. No group worth its salt in Washington seems to be without a proposal. Some of them mesh, some of them don't. Viewed from the heartland it appears to be less an orchestrated chorus than a cacophony of well-intended but often unintelligible noises. It is time for Congress and the Administration to turn down the noise and turn up the harmony. The country needs action and it needs it soon.

If there is going to be a program that provides equal access to quality health care regardless of ability to pay, I urge you not to repeat the mistakes of our current programs. They are not models for reform; they need to be reformed.

Medicaid, for example, is in disarray throughout the country. In Illinois it is only a shameful shadow of our lowest expectations for a public program designed to be a safety net for the poorest of the poor. To be eligible for Medicaid in our state a family of three can earn no more than $4,400 a year. If you are a doctor you're paid about 40% of what it costs to treat a Medicaid patient. If you're a hospital in Illinois you get paid about 70 cents for every dollar you spend caring for a Medicaid inpatient, and less than 50 cents for each dollar spent caring for outpatients. Illinois hospitals are paid about $350 million dollars less per year than they spend treating Medicaid patients.

And if you are a Medicaid provider in Illinois in 1991 you can expect to wait well over 100 days to get paid. In effect, because the state has both underfunded the program and is in the midst of a cash shortfall, it has begun to use hospitals as its bankers. It borrows interest free money from hospitals by not paying its bills on a timely basis. It has a prompt payment statute that it has ignored for years and intends to repeal for the future. It pays its employees promptly, it finances sports and convention facilities with tax dollars, and it finds the money for foreign trade offices, but it ignores the plight of its most vulnerable citizens.

Our former Governor liked to claim that Medicaid was the monster that ate the state's budget. The truth is that in 1980, Medicaid consumed 18% of the budget, and in 1990 it only accounted for 17% of the budget. The budget grew, all right, but not because of Medicaid spending. In real, inflation adjusted dollars, hospitals were paid $1.339 billion in 1980 and only $885 million in 1990. According to data provided by the American Hospital Association, Illinois ranks dead last in the nation in Medicaid reimbursement.

The federal government is not without complicity in Illinois' Medicaid tragedy. In 1985 the Department of Health and Human Services issued a waiver of the Boren Amendment reasonable payment standards, among others, that all but two other state programs are required to abide by. Illinois took the opportunity presented by that waiver to drive its payments to hospitals down to 62% of the cost of care. And HHS, in its oversight capacity, uses a rubber stamp to review these programs when a microscope is needed.

The situation worsens by the day. Facing the choice of either raising taxes to restore a $1.5 billion dollar budget shortfall or slashing spending, our new Governor has chosen the latter. His fiscal year 1992 budget proposal cuts 19% from what already is the lowest paying program in the nation. Illinois has a budget policy; it clearly does not have a health care policy.

Twenty two hospitals have closed in Illinois since 1985 -- about half of them in the metropolitan Chicago area -- and, according to the former Director of the Illinois Department of Public Aid, about half of those closures were a direct result of Medicaid underfunding. Analysts predict that three of the remaining six hospitals on the west side of Chicago will close within 36 months unless the state's Medicaid spending increases. Many remaining hospitals are developing survival strategies which include conscious efforts to reduce their Medicaid exposure. Patients do not have adequate access to primary care; 75% of all Medicaid services are provided by only 15% of Illinois' doctors. Hospital emergency rooms have become the surrogate physicians' offices in the inner city -- emergency rooms that themselves need emergency care. The sum of these deficiencies is reduced accessibility to basic health care services for the medically indigent.

While Medicare is also a contributor to the economic hardships of hospitals, it does so in a less intentional, less malicious way. Like Medicaid, it pays our hospitals about $300 million less than we spend treating Medicare patients. We have advocated to Congress for more equitable payment policies for the high cost of doing business in states like Illinois; we have disputed the adequacies of annual update amounts; and we argue about the necessity and wisdom of folding capital payments into the DRG payment structure. But for all that, fairness also compels me to note that Congress has been reasonably attentive and fair in listening to our concerns, and the Prospective Payment System's incentives for more efficient hospital behavior have been appropriate and effective. It is a rational payment device. It distributes payments with due regard for resource consumption. It is not perfect, but it is practical and it is amenable to fine tuning as we learn more about its foibles.

The remaining major issue is access to care for the medically indigent. There are over 1.5 million of them in Illinois, about half of whom work either part or full time. We spend over $450 million a year to care for them.

Three years ago the Illinois Hospital Association prompted introduction of a bill in the state legislature, entitled Accessible Care Today -- or ACT -- which was designed to require most employers to provide a basic set of health insurance benefits to their employees. We were disappointed in the reaction of our business community. They organized a lobbying effort entitled Businesses Against Mandated Benefits -- or BOMB. It was BOMB against ACT. And that battle of the acronyms seems to sum up the negative, reactive role of business in dealing with this problem. Despite the fact that cost shifting in Illinois increases the average commercially insured patient's bill by about 35%, with the result that those businesses which do insure their employees are subsidizing those who don't, the best that the business community could do was to be against something and for nothing.

The net result of all of this is about $1.2 billion in cost shifting by hospitals in Illinois. We have become in only a few short years bankers to the state of Illinois, sick tax collectors for state and federal governments, transfer agents for taking from those who have to give to those who don't. While transfer payments may be good social or political policy, let's at least decide upon them as explicit policy choices arrived at only after an honest and complete political debate about their effects, their benefits and their liabilities.

Legislation to solve our nation's health policy dilemma has recently begun to surface. Congressman Marty Russo from Illinois, a member of this committee, has joined the increasing number of those who have offered universal health insurance or access plans. Senator George Mitchell and other of his concerned colleagues have also joined the debate. We commend them for bringing this issue into the public spotlight. There is enough food for thought in all of these proposals to create a veritable banquet of debate for all of us who want to convert concern to action. We will be happy to engage fully in that debate and we hope that you'll continue to listen to us and other thoughtful and concerned citizens as we struggle to find a common solution to these issues.

But most of all, as you engage in this important debate I hope you don't lose sight of the Illinois experience. For those who see Medicaid as the umbrella that will protect the poor from the stormy weather of medical indigence, look at a state drowning in indifference toward its current

Medicaid program. It is the ultimate example of well intentioned people with political and budgetary agendas that ignore the consequences of those agendas on the health of our citizens. An expanded Medicaid program is not the panacea solution. When you put all your eggs in one basket, the ones on the bottom tend to break. And in our society, the poor and the hospitals who serve them often end up on the bottom.

Thank you.

Chairman STARK. Thank you, very much.

I had a couple of questions for the both of you. Dr. Aronson, at the end of your testimony, you said you oppose a single-payer system. But then what you are saying to me is that you want a one-class system of care. That makes sense. You want uniform benefits, fair compensation and if that's reasonable and fair that makes sense to me, too. But it sounds to me if you have one class of patient care and you have a uniform benefit, then somebody has to make the decision in some area, at least, as to what's fair and reasonable compensation, and you get pretty close to a standard fee.

It's hard for me to see a lot of variety in fees, and particularly, let's just take a well-baby program for the first year of life, and you get a fixed rate sort of thing, as I remember, $800? No, does $80 sound right? No, even 30 years ago?

Dr. ARONSON. I am not sure that there is a single package rate for an entire year's care unless you are in a managed care program, but I understand where you are coming from.

Chairman STARK. But what I'm saying is, it seems to me the only thing you gain by not having a single-payer is this sense that you are more independent and you don't have to bargain with some monolithic government. As far as I am concerned, it can be Blue Cross—but this is where I think I can sell you—all you need to know is that everybody who comes into your waiting room has a card. And all you do is zip that card through a little gizmo next to your phone and punch in the number of the procedure you have just performed and the money is in your bank account.

No form, no nothing. I just have a hunch that I could sell the docs in this country if they really believed that the money would be in their bank account—now, we would come in and audit you just in case you were making up patients or that you bought cards from some guy who was off stealing them, but basically the only way we will ever get rid of the hassle is through some kind of a single payment system.

You save a lot. I have heard it suggested that hospitals with a system like that could save, on the average, one employee per bed. Now, that may be high. Some of the hospitals in my district will spot me half an employee per bed and I don't think a hospital can have an employee for less than $20,000 a year.

Mr. ROBBINS. The debate would be on the margin of your number, not on the substance of it.

Chairman STARK. Yes, and I don't know in a physician's office, I don't know how that breaks down, because many of you may only have one other employee and obviously you don't have any room for marginal saving there. But comment on that. What troubles you about the single-payer?

Dr. ARONSON. Mr. Stark, the academy is not opposed to a single-payer system. The testimony says, we don't favor a single-payer system, and there are some reasons that we——

Chairman STARK. You guys are so nice though. This we don't favor, is as nasty as you get.

Dr. ARONSON. We have other preferences. Unfortunately the beneficiary population we are talking about today are low-income poor and near-poor people.

The single-payer system known to most pediatricians, the Medicaid system has failed miserably, as you have heard this morning, for patients and physicians——

Chairman STARK. You know you don't get into Medicare very much.

Dr. ARONSON. Not many pediatricians are familiar with Medicare.

Chairman STARK. Are you familiar with PPRC's pediatric fees under the new resource based relative value scale? I am not sure what they are. We have them because we do have occasional beneficiaries in Medicare who are children, but——

Dr. ARONSON. Yes, sir, and I was the academy's representative to the PhysPRC discussions. The academy has provided testimony which indicate that if Medicaid fees were increased to Medicare fee schedule levels, that would approximate about 85 percent of market rates——

Chairman STARK. Today?

Dr. ARONSON [continuing]. And would probably induce 90 to 100 percent participation, essentially full unrestricted participation by physicians in the current Medicaid system. Now, to the extent——

Chairman STARK. Now, if it is 85 percent of market fees under the RBRVS, and you got immediate payment and no billing, we'd be pretty close to making up that other 15 percent, just in overhead savings. What do you think would happen to the average net income of pediatricians if they just said, OK, we'll take Medicare for every person who walks through the door? Would your colleagues pretty generally be about as well off as they are?

Dr. ARONSON. I am not prepared to comment on what that's going to do to the average net income of the pediatricians but let me share something with you——

Chairman STARK. Would you guess for me, though?

Dr. ARONSON. My practice is across from city hall in Philadelphia and Pennsylvania Medicaid pays me 48 percent of my charges. My overhead, because I am in a high-rent district, is about 58 percent. About 10 percent of my total patient encounters per month are Medicaid. I don't hold any barriers to Medicaid participation. As I said, I am an EPSDT provider. Clearly I would be much more interested in seeing far more Medicaid participants if Medicaid was paying me 85 percent of my market rate, than 48 percent as currently is the case.

Our concern, at the academy level, is to see to it that more children have access to mainstream care, a medical home in the community for the majority of services which children require—preventive oriented child health supervision and episodic care. And let's not let Mr. Eizenstat's hospitals become the provider of last resort for total care. That is not good care, it is not comprehensive, it is not preventive oriented and it is extraordinarily costly.

We support and would be interested in discussing further any discussion which improved access of low-income kids to and pregnant women to community-based care which is preventive oriented.

Chairman STARK. You are not going to get any quarrel from those of us here today. You might in general, but you know trying to get to where you would like to be from where we are is a big step. It is easier, I think, with pediatricians, because if we used any

system that we come up with that has some costs, you guys make relatively so little that you are really not opposed to much of what we may have to do. Now, I can't say that about some of your brethren in the more highly paid specialties, in the more esoteric specialties, because they arguably are going to take a bigger hit.

Dr. ARONSON. I believe that the PPRC data shows a $2.3 billion increase—about a 4 percent increase in total Medicaid expenditures—if Medicaid fees were increased to Medicare fee schedule levels for selected procedures and selected physicians in a targeted way a doable and achievable goal.

Chairman STARK. I wanted to ask Mr. Robbins about using Medicare as the insurance for the United States. My statement has often been that if the hospitals of the United States, again on the average—got the Medicare rate for everybody who walked through the door, they could survive. No more uncompensated care, no more charity care. How would you respond to that? How would Illinois—three of your members would vote for that and how many would vote against it?

Mr. ROBBINS. Let me try to answer it this way, in a very specific fashion. We introduced legislation this year into the Illinois General Assembly that would replace the current Medicaid payment system with a Medicare look-alike DRG based payment system using Medicare weights suggested for Medicare patient populations. And clearly the Medicaid program is an inadequate vehicle of delivery as it is now constructed. Medicare is a rational system for distributing resources in relation to the consumption of those resources.

We argue with you from time to time over the adequacy of the updates or the capital ought to be folded in and all that kind of thing, but as you compare it to Medicaid, clearly Medicare is a preferable payment system. In Illinois we calculate that it pays us about 90 percent of our costs. And whether the efficiencies of distributing that delivery system over the entire base of patients would accomplish a closure of that cost gap, I think would be the real question for us.

Chairman STARK. It would be real close. OK, then if there were a choice presented to your members about going to locally funded annual budgets the way the school system does or the police department does, or going to a national DRG rate, which one would they choose?

I mean would they——

Mr. ROBBINS. I think they are prepared to engage in that discussion. I think I can speak for the hospitals in Illinois by saying that the leadership of that group believes that we are due for a fundamental change in the way that health care is paid for and delivered and distributed and that that is coming, I think, clearly there is no more than a 5 to 10 year window and it is going to be dramatic change.

As far as I am concerned all of those issues ought to be on the table and ought to be discussed. I think they will have great fear that Government will not be a faithful partner and that as it establishes those global budgets they will look good on the front end, and whether it be Federal or State, will always be subject to budget policies not health policies.

Chairman STARK. Coming from Illinois and knowing Sister Sheila, and Chairman Rostenkowski, I hope you understand what I mean by 90-year-old hood ornaments, and the advocacy that the Medicare beneficiaries bring to us. I would worry if I were running a hospital or if I were a physician, I would just as soon have, whether it is AARP or Jimmy Roosevelt or Families USA fronting for me to better my situation.

Mr. ROBBINS. The poor have no political power. They have no representation that matters and I think the elderly, too.

Chairman STARK. The elderly have the time?

Mr. ROBBINS. Yes.

Chairman STARK. And by then the sophistication and the interest to vote more, and they have the ability to write letters and the time to do it, and I don't think there is anything wrong with hitching your star to that group as a way to protect your program. I think it is a hollow argument to say, look what happened to Medicaid. The same would happen if we go to Medicare. I think that clearly the group being representative——

Mr. ROBBINS. I might tell you that the Governor of our State is opposed and has threatened to veto that bill which has passed the legislature because it would cost the State to spend about $300 million more in its Medicaid program than it is currently spending.

Chairman STARK. But at least, Illinois did not have the stupidity to vote in a proposition 13, we really hamstrung ourselves in California.

Mr. ROBBINS. We did the next best thing. The Governor ran on a campaign of no new taxes and——

Chairman STARK. I have heard that clarion call before.

Mr. ROBBINS. And it seems like he might keep his promise.

Chairman STARK. Mr. Coyne, do you want to defend Pennsylvania here?

Mr. COYNE. I have no questions.

Chairman STARK. I appreciate the witnesses' candor, and as always, the Academy of Pediatrics has been, I think, in the forefront of trying to bring some rational compromise to this system and make it better. I hope that you will continue to participate with your own provider groups. I keep thinking that it is the provider system that needs change the least, but would be the toughest to change politically. The easiest system to approach is the system of health financing, because my voters don't know much about it—they really don't know how their bills are getting paid anyway. So we might as well deal with financing, it is less threatening, and I think I did allude to Sister Sheila earlier who has become a mythical and magical figure to this committee for reasons that are somewhat arcane but obviously——

Mr. ROBBINS. Mr. Chairman, she was on my board about 3 years ago and I fully understand.

Chairman STARK. She is, in the vernacular, a piece of work and we appreciate her. Thank you both again for your testimony, we appreciate it.

The committee stands adjourned.

[Whereupon, at 12:34 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

TESTIMONY OF DAVID SATCHER, M.D., PH.D.
ON BEHALF OF
THE ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

Background Statement

In his January 29, 1991 State of the Union address, President Bush stated that "good health care is every American's right and every American's responsibility". The Association of Minority Health Professions Schools (AMHPS) supports President Bush's assertion that health care for every American is a right and not a privilege. In order to make that right a reality, AMHPS strongly supports reform of our national health care system which insures health care services to anyone who needs access to health care. Access to health care should not relate to one's ability to pay. The issue must be placed on the national agenda immediately.

Disparities in access to health care is the dominant factor which accounts for the growing disparity in the health status between blacks and other disadvantaged minorities and the general population of the U.S. Improved access to health care is of paramount importance in achieving the AMHPS mission to improve the health status of minority and disadvantaged persons and must be the primary component of health care reform. National health care reform is absolutely essential in order to address the crises of lack of access to proper health care for minorities. It is important to note that in the last few years policy makers have debated the merits of various health reform plans. The federal government must demonstrate leadership by addressing this crises now.

Health Care Reform Proposals

Recently, there has been significant debate about various health care reform programs. The current debate has not addressed the crises because no health reform program appears close to being enacted by the Congress. The process for enacting reform appears to have ended before it began. Several reports that attempt to reach a consensus on the best process of health care reform include the Health Leadership Commission which issued two minority reports after two years of consideration.

One report from Corporate America felt that the Commission's proposal put too much money into the hands of providers, especially physicians, by providing universal access programs with payer pools at the state level. This report felt that more emphasis should be placed on cost containment and less emphasis on increasing access.

Another minority report from the American Medical Association (AMA) felt that the Leadership Commission's proposal was too critical and too negative about physicians in its analysis of the present health care system. Other reports on this topic, ranging from the National Association of Social Workers to the U.S. Bipartisan Commission on Comprehensive Health Care clearly indicate that there are too many ramifications and too many conflicting political agendas to allow groups with large constituencies to successfully develop a viable proposal. Therefore, we are recommending a different process to developing a health care reform proposal - one in which President Bush and his Secretary for Health and Human Services would define some desired outcomes such as universal access, measures to control cost, and a program to evaluate appropriateness and quality of care, as well as some built-in economic and other incentives.

Given the defined objectives or desired outcomes, a group of people should be brought together based on their technical skills not based on their representation of different organizations or constituents. Given their technical skills, they should be asked to develop a system that would best provide the outcomes which have been defined and, at the same time, have a measure of political feasibility built into it. This technical group, or task forces must be politically neutral in coming up with a proposed program or programs.

Health Status Disparity

Blacks and other disadvantaged minorities do not enjoy the same health status as other Americans. The 1985 Health and Human Services Secretary's Task Force Report on Black and Minority Health demonstrated that there indeed was and is a significant health status disparity among blacks and other minorities as compared to the general population of the U.S.

Since this historic report by the Secretary in 1985 the health status gap has widened. The National Center for Health Statistics recently reported that black life expectancy has decreased from 69.7 in 1984 to 69.2 in 1988. AIDS, which was not even mentioned in the 1985 report is now a leading cause of death and disproportionately affects blacks and other minorities - minorities who constitute 24% of the U.S. population but 45% of our AIDS victims. AMHPS believes that in addressing the enormous problem of this health status disparity, a firm commitment from the federal government to the users and payers of health services must be made.

AMHPS Institutions

AMHPS is comprised of 8 historically black health professions schools which have trained 40% of the nation's black physicians, 40% of the nation's black dentists, 50% of the nation's black pharmacists, and 75% of the nation's black veterinarians.

AMHPS institutions have been at the vanguard of addressing the enormous need to close the gap in the health status disparity between the minority and majority populations, to increasing the number of minorities in the health professions and to serving the indigent and the underserved.

Health Care Reform is Urgent

There are approximately 37 million Americans who have no health insurance. Millions of disadvantaged Americans are not able to pay and receive health care. This has contributed significantly to the now unacceptable cost and growth of health care in this country. Health care costs have grown faster than inflation every year since 1980 and have grown 11 percent since 1988. Additionally, health programs as a percentage of the federal budget continue to increase while costs have increased by almost half to large and medium-sized companies. Employers who do provide health insurance, public hospitals and people with health insurance subsidize the costs of uncompensated care. It is the absence of health care for minorities and the poor which results in skyrocketing health insurance premiums for the middle-class.

This points out that health care reform cannot be accomplished piecemeal. Rather what is needed is a complete overhaul of our health care system to provide universal access, cost-containment and quality assessment.

The current situation is unacceptable and demands urgent action by the federal government. Most importantly, every day that health care reform is delayed, blacks die. Every day that health care reform is delayed, minority health professions institutions experience greater financial instability.

From 1977 to 1987 the relative increase in the number of persons without insurance was greater among minorities than whites. During that time span, the number of uninsured whites increased by about 28 percent while the number of uninsured blacks nearly doubled from four to seven million and the number of uninsured hispanics increased three-fold from two to six million. Thirty-five percent of hispanics under age 65 and 26 percent of blacks, were uninsured in 1987 compared to 15 percent of whites. The increase between 1977 and 1987 in the proportion of uninsured hispanics was five times the increase for whites. For blacks, the increase was twice that for whites. The declining proportion of blacks with health insurance is mainly due to a reduction in

private insurance, with public coverage declining.

As the 1985 Secretary's Task Force on Black & Minority Health revealed, "Many ... minorities tend to rely on Medicaid and charity care for their medical treatment because they have no other sources of care or ways to finance that care ..." Further, minorities are disproportionately poor and unemployed, consequently they disproportionately experience the barriers to health care associated with poverty. Under the current system of health care insurance, poor people are too often excluded from the process. There is a correlation between the problem of criteria for eligibility into the process of health cost reimbursement and the problem of poor access to health care by the poor. Health care coverage is often provided through employment, so for minorities access to health care is often obstructed through unemployment and through employment with businesses such as many of those in the service industry that do not provide health insurance. Many other barriers exist as a result of poverty which prevent access to health care, including lack of available health care personnel, transportation, and other cultural barriers. Economic and other barriers to the receipt of health care must be eliminated. Universal access is every American's right. Finances must not be a barrier to health care.

General Recommendations

AMHPS believes that the following general criteria are essential elements to any health care reform plan. The plan must provide (1) universal, comprehensive coverage. It must (2) maximize cost efficiency through cost containment and it must (3) include a quality control and evaluation component.

Healthy People 2000: National Health Promotion and Disease Prevention Objectives, submitted by the Department of Health and Human Services just last year, outlined basic goals for health improvements - including the elimination of disparities among population groups and access to necessary preventive services for everyone. Many health problems are associated with poverty, such as lack of access to basic health care for the underserved which causes these disparities and it will only be through health care reform that these problems can begin to be addressed.

National Health Care Reform must also maximize cost efficiency. Health care costs have risen beyond control. The U.S. spends over 600 billion dollars per year on health care. Per capital health spending is greater in the United States than in Canada, yet our nation has a lower life expectancy and a higher rate of infant mortality. A national health care reform program should stabilize health expenditures as a percentage of the national income and reduce the problems of uncompensated care and individual burdens of catastrophic illness. In order to achieve these objectives such a plan must redirect available resources to the weaknesses of the system. Too often, funding that was originally intended to help the indigent does not reach the indigent. The flow of resources to the underserved is not being appropriately applied. A redirection of resources to institutions that provide quality care to the disadvantaged, to the underserved and to the indigent, is an important component of any national health care reform program. There must also be a focus on preventive medicine and primary care.

Finally, a national health care reform program must include a quality control component to ensure that reforms are not exacerbating existing problems but are successfully improving health care access at affordable costs. AMHPS is not calling for universal health insurance.

The Process

In the last year alone, several major health care associations, as well as the Pepper Commission have developed national health reform programs. Yet without Executive leadership

and differences over the various aspects of the several proposals, no work has begun in Congress to enact a new health coverage program. Whether the means toward achieving universal access to health coverage include incentives for employers to provide health care coverage and support for public programs that provide access to basic health care benefits for the uninsured or not, what is important is to recognize that alleviating the problem of the health status disparity between disadvantaged minorities and the general population is crucial. A technical agreement must be reached prior to implementation by Congress.

Black Americans are experiencing a health care crisis. The President and the Congress must exert leadership and enact legislation to improve access to health care for minorities. Action must not be delayed any longer.

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
ROBERT C. GATES, DIRECTOR

STATEMENT
FOR CONSIDERATION OF THE
SUBCOMMITTEE ON HEALTH
HOUSE WAYS AND MEANS COMMITTEE
REGARDING
HEALTH INSURANCE STATUS OF THE INDIGENT

More than 30 million Americans are estimated to be medically unsponsored: that is, unable to pay for medical care out of pocket and not covered by private or public insurance. About 16 million of these are children under 21. Yet, the system of medical care needed to provide coverage to the medically unsponsored is already in place. It is, however, greatly underfunded. That system is the county safety net.

When considering how to extend access to all Americans in need of medical care, Congress should look to that existing system as one of its major resources. The mere extension of coverage to these individuals will not assure them access to care unless Congress also takes steps to assure that the facilities to provide care exist and are properly funded.

THE INADEQUACY OF MERE COVERAGE: THE MEDICAID POPULATION

The California experience documents dramatically the ineffectiveness of mere extension of coverage. In California, virtually every pregnant women under 200% of poverty level is eligible for Medi-Cal (Medicaid) along with her infant children. Yet the access of these women to care is in practice problematical.

In many parts of the state, it is difficult for these patients to find an obstetrician who will accept Medicaid patients. Our review of Medi-Cal claims tapes indicates that the number of obstetricians treating Medi-Cal patients is not keeping pace with the demand. For example, in 1987, half of California's 58 counties had so few obstetricians who took Medi-Cal patients that services were virtually unavailable for the 175,000 Medi-Cal-eligible women of childbearing age in those counties (almost 30% of all eligible women in the state). (Back to Basics 1988; Report of the Southern California Child Health Network, page 7)

In Los Angeles County, demand for obstetrical care far exceeds the normal capacities of county facilities. Projections for the future predict a constant worsening of the overcrowding situation. To relieve our own overcrowding, we actively seek contracts with private hospitals to accept those of our patients who are Medicaid beneficiaries. In doing this, we act as intermediaries between the hospitals and California's cumbersome Medi-Cal billing process, and in some cases provide malpractice coverage for noncounty physicians. This is necessary because the Medi-Cal program is not structured in a way to motivate private participation.

One major cause of the unwillingness of private providers to participate in Medi-Cal is the inadequacy of rates. Payments to California physicians for outpatient services do not cover even half of the charges. Another demotivator for Medicaid participation is the complexity of billing and the slowness of

payments. Still another is the arbitrary manner in which payment for medically necessary treatment may be denied. For example, in the case of infants suffering drug withdrawal symptoms because of their mother's use of drugs, Medi-Cal may deny extension of the baby's hospital stay if the infant does not test positive to the presence of the drug in his body.

Another important demotivator is the fact that high-risk patients are concentrated in the low-income population. Hospitals accepting these patients both incur higher costs and increase the risk of negative outcomes. This also heightens their exposure to liability and could increase their insurance costs. It has been estimated that medical malpractice litigation and judgments add 2% to medical costs not counting the costs of "defensive medical practices."

Congress can extend medical coverage to the medically unsponsored by expanding Medicaid or by creating some new program to cover these patients. In either case, expanded coverage will not create expanded access unless Congress also helps assure adequate funding of the capacity to provide care to these patients.

INDIGENT PATIENTS: THE MEDICALLY UNSPONSORED

Medicaid patients make up a population which has the deceptive appearance of coverage but has in fact only limited access to care. Another population, that of the medically unsponsored indigent, has no "coverage" but at least in Los Angeles County this group has almost as good access to care as the Medicaid population. Their access is based on state laws which impose on counties the responsibility to be the provider of last resort for this population. These laws exist in many states outside California as well. This role of counties is the safety net function.

The problem with care to the indigent is not that it does not exist. It is rather that it is underfunded.

Within the limits of the inadequate funding, however, counties actually do provide care to the medically unsponsored. For example, Los Angeles County operates six hospitals, five comprehensive health centers and more than 40 health centers. Each year, these facilities provide more than one million days of inpatient care, more than four million outpatient visits, and about 300,000 emergency room visits. The overwhelming majority of patients in this system are either indigent or beneficiaries of the two existing major federal programs, Medicaid and Medicare. The system which provides this care represents a major investment already made in existing facilities.

When Congress considers expansion of access to medical care, it will also be necessary to look at several alternative methods of providing that access. Despite the problems caused by the current underfunding, the county safety net already has a number of potential advantages compared with other alternatives. Adequately funded, this system has the potential to be the best choice as a means to assure care to the poor.

-- It is already in place and doing the job - to the extent that the job is done at all.
-- County facilities tend to be situated at sites close to where low-income people live.
-- County personnel are experienced in dealing with the multiethnic groups which help make up the population of the poor. In many cases, county staff comes from the same ethnic groups as their patients. For example, employees of the Los Angeles County Department of Health Services speak

more than 35 languages, including Arabic, Armenian, several Chinese languages, Hindi, Indonesian, Japanese, Persian, Russian, Samoan, Spanish, Tagalog and other languages of the Philippines, Thai and Urdu: all languages spoken by our clientele.

-- The large number of immigrants from all parts of the world gives county personnel unique experience in treating rare and exotic diseases which are less common in the United States. As a result, county facilities attract trainees doing their residency and internship in noncounty facilities but who request a term of placement in a county facility in order to have that experience.
-- County personnel are at ease with persons from the lower economic brackets which many private facilities would prefer not to have even if payment for their treatment were adequate.
-- Years of underfunding have enabled county facilities to minimize the cost of care. For example, in 1988-89, the Los Angeles daily county hospital cost of $746 was 13% lower than the California statewide average, and 45% lower than the University of California hospital cost.

CONSIDERATIONS IN EXPANDING ACCESS

Los Angeles County does not prefer one method of expanding coverage over other methods. Whatever method Congress adopts, however, should have at least the following features:

-- It should make use of and expand the existing county safety net because of the advantages described above. At the same time, we agree that the problem needs a unifying federal approach to assure uniform minimum standards nationwide and to counteract tendencies of people to move toward the first states that institute their own programs.

-- It should cover the unemployed as well as the employed.

-- It should contain a realistic and stable funding base for the program and subvention of local costs for those, if any, left uncovered. The unpredictable funding base is as disruptive to access as the underfunding.

-- It should contain a rate structure adequate to assure sufficient private sector participation in the program. That structure should also be sufficient to allow for capital projects for needed improvement and expansion in the public sector.

-- It should contain effective assurances against arbitrary denials of payment for necessary care provided in emergency situations.

-- It should provide for maximum simplification of billing procedures and assurances against undue delays in payment.

-- It should contain reform measures to reduce the abuses of medical malpractice litigation. This will allow lower rates because litigation and judgments are also provider costs.

COST CONTROL RECOMMENDATIONS

Taken in isolation, some of the foregoing recommendations could, if adopted, lead to substantial cost increases. While it is unrealistic to expect a meaningful expansion of access without added costs, it should be possible to contain these costs within reasonable limits. To do this, however, it may be necessary to

limit the expansion of access to less than ideal proportions. Application of the following principles could help achieve that balance:

-- Whatever the program adopted by Congress, it cannot rely on depression of rates as its primary cost control measure. This method has already been tried without success; it leads only to cost shifting and restriction of access. Cost control measures must aim not only at the provider, but at the user as well. In keeping with this principle, proposals for universal access should consider explicit priority-setting and rationing for rare and technologically costly procedures. Although rationing is a negative term for many people, an effective improvement in access coupled with rationing would improve the lot of the more than 30 million medically unsponsored in America. Theoretically, these individuals may now have access to procedures that might be rationed. In fact, however, many of these patients do not even have access to basic care.

-- Proposals to expand access should create incentives for demonstrated cost-effective preventive measures, especially for prenatal, infant and pediatric care.

-- The requirement for the user to share in costs can function as a cost control measure. Share of the costs should be selectively applied to reduce demand for those procedures whose overuse contributes to explosive growth of medical care costs.

-- Any proposals which effectively increase access will also increase the nationwide need for medical professionals available to serve the poor. It might be wise, therefore, to couple any new proposal with provisions to subsidize medical professional training in exchange for a binding commitment by the student to serve for a specified number of years in a national medical service corps on a salaried basis assigned to areas of high need. Further, in this context, the proposal should address the special needs of public facilities which provide medical education and training.

-- There should be adequate funding for aggressive prosecution of fraud. There is increasing evidence that large-scale medical fraud operations are a significant factor in national medical care costs.

-- Tort reform measures should protect providers from liability except for gross negligence. Failure to provide a rationed procedure, or to provide it in a timely manner, should not be allowed as a cause of action. The law needs to be changed so as to remove the provider's need to practice "defensive Medicine."

CONCLUSION

These recommendations will not lead to a system of medical care which promises all things to all people. The limited objectives presented here will still leave gaps in a national system of medical coverage. For the large and growing number of medically unsponsored and underinsured in the United States, however, these recommendations propose a substantial improvement in their present access to health care at a price which the nation might be willing to pay.

wp3.jbe.w&mtst
7/9/91

46-756 0 - 92 (87)

ISBN 0-16-037366-2
90000
9 780160 373664